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ABSTRACT

The purpose of H.R. 2600, which is commonly referred to as the Comprehensive School Health Education Act, is to encourage the provision of comprehensive programs in elementary and secondary schools with respect to health education and health programs by establishing a system of grants for teacher training, pilot and demonstration projects, and the development of comprehensive health education programs. These hearing include statements before the actual committee and prepared statements, letters, and supplemental materials submitted to the committee. All of the people who testified before the committee, excluding Senator Clark, were in some capacity related to the medical field, the health education field, or the education field. (SK)

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SB

COMPREHENSIVE SCHOOL HEALTH EDUCATION ACT

HEARINGS

BEFORE THE

SUBCOMMITTEE ON ELEMENTARY, SECONDARY AND VOCATIONAL EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR

HOUSE OF REPRESENTATIVES

NINETY-FOURTH CONGRESS

FIRST SESSION

ON

H.R. 2600

TO AUTHORIZE THE COMMISSIONER OF EDUCATION TO MAKE GRANTS FOR TEACHER TRAINING, PILOT AND DEMONSTRATION PROJECTS, AND COMPREHENSIVE SCHOOL PROGRAMS, WITH RESPECT TO HEALTH EDUCATION AND HEALTH PROBLEMS

HEARINGS HELD IN WASHINGTON, D.C.
MARCH 11 AND 12, 1975

Printed for the use of the Committee on Education and Labor

CARL D. PERKINS, *Chairman*

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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COMPREHENSIVE SCHOOL HEALTH EDUCATION ACT

WEDNESDAY, MARCH 12, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ELEMENTARY, SECONDARY, AND
VOCATIONAL EDUCATION OF THE COMMITTEE
ON EDUCATION AND LABOR,
Washington, D.C.

The subcommittee met at 8:30 a.m., pursuant to call of the Chair, room 2257, Rayburn House Office Building, Hon. Lloyd Meeds presiding.

Members present: Representatives Perkins, Meeds, Risenhoover, Mottl, Blouin, and Quie.

Staff present: John F. Jennings, majority counsel; and Christopher T. Cross, minority legislative associate.

Mr. MEEDS. The hearing will come to order.

The Subcommittee on Elementary, Secondary, and Vocational Education will be in order for the purpose of taking testimony on bill H.R. 2600, and companion bills.

[Text of H.R. 2600 follows:]

94TH CONGRESS
1ST SESSION

H. R. 2600

IN THE HOUSE OF REPRESENTATIVES

FEBRUARY 3, 1975

Mr. MEEDS (for himself, Mr. PERKINS, Mr. DAVIS, Mr. OTTINGER, Mr. NIX, Mr. BROWN of California, Mrs. MINK, Mr. BOLLING, Mr. BENITEZ, Mr. BADILLO, Mr. HICKS, Mr. SOLARZ, Mr. FORD of Michigan, Mr. HELSTOSKI, Mr. DELLUMS, Mr. FRASER, Mr. MITCHELL of Maryland, Mrs. COLLINS of Illinois, Mr. CLAY, Mr. HAWKINS, Mr. PEPPER, Mr. MORGAN, Mr. DE LUGO, Mr. WAXMAN, and Mr. LEHMAN) introduced the following bill; which was referred to the Committee on Education and Labor

A BILL

To authorize the Commissioner of Education to make grants for teacher training, pilot and demonstration projects, and comprehensive school programs, with respect to health education and health problems.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SHORT TITLE

SECTION 1. This Act may be cited as the "Comprehensive School Health Education Act".

FINDINGS AND PURPOSE

SEC. 2. (a) The Congress finds that—

(1) health education in the schools has the potential for enhancing the quality of life, raising the level of

health for the student's lifetime by significantly reducing those health problems susceptible to educational intervention, and favorably influencing the learning process;

(2) the provision of a comprehensive program with respect to health education and health problems for the children and youth of the Nation should be given high priority; and

(3) most children and youth of the Nation now do not have an opportunity to participate in comprehensive health education programs, since health education in many schools either is nonexistent or is provided on a fragmented and inadequate basis.

(b) It is the purpose of this Act to encourage the provision of comprehensive programs in elementary and secondary schools with respect to health education and health problems by establishing a system of grants for teacher training, pilot and demonstration projects, and the development of comprehensive health education programs.

DEFINITIONS

SEC. 3. For purposes of this Act—

(1) the term "Commissioner" means the Commissioner of Education;

(2) the term "health education and health problems" includes dental health, disease control, environ-

mental health, family life and human development, human ecology, mental health, nutrition, physical health, safety and accident prevention, smoking and health, substance abuse, consumer health and venereal disease; and

(3) except as provided by section 6(b), the term "State" means the several States, the Commonwealth of Puerto Rico, the District of Columbia, Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands.

TEACHER TRAINING

SEC. 4. (a) The Commissioner may make grants to State educational agencies and institutions of higher education for teacher training with respect to the provision of comprehensive health education programs in schools. Such grants may be used by such agencies and institutions to develop and conduct training programs for elementary and secondary teachers with respect to teaching methods and techniques, information, and current issues relating to health and health problems.

(b) The Commissioner shall distribute grants under this section in a manner which insures the most effective and equitable distribution of such grants and which seeks to achieve a reasonable geographical distribution. The Commissioner shall, not later than thirty days before he distributes grants under this section, transmit a report to the Committee on Labor and Public Welfare of the Senate and to the Committee on Education and Labor of the House of Representa-

tives. Such report shall contain a detailed statement of criteria which the Commissioner proposes to use in distributing grants under this section.

(c) There is authorized to be appropriated $10,000,000 for the fiscal year ending June 30, 1976, $12,500,000 for the fiscal year ending September 30, 1977, and $15,000,000 for the fiscal year ending September 30, 1978, to carry out this section.

PILOT AND DEMONSTRATION PROJECTS

SEC. 5. (a) The Commissioner may make grants to State and local educational agencies, institutions of higher education, and other public or private nonprofit education or research agencies, institutions, or organizations to support pilot demonstration projects in elementary and secondary schools with respect to health education and health problems.

(b) Grants under this section shall be available for the following pilot and demonstration projects—

(1) projects for the development of curriculums on health education and health problems, including the evaluation of exemplary existing materials and the preparation of new and improved curricular materials for use in elementary and secondary education programs;

(2) projects for demonstration, testing, and evaluation of the effectiveness of such curriculums (whether such curriculums are developed with assistance under this Act or otherwise);

(3) in the case of applicants who have conducted projects under paragraph (2), projects for the dissemination of curricular materials and other information with respect to health and health problems to public and private elementary and secondary education programs; and

(4) projects for preservice and inservice training programs with respect to health education and health problems (including courses of study, institutes, seminars, workshops, and conferences) for teachers and other educational personnel.

(c) Grants under this section shall be available for evaluations of—

(1) the effectiveness of curriculums tested in use in elementary and secondary education programs involved in projects under subsection (b) (2); and

(2) the training programs developed under subsection (b) (4), including examination of the intended and actual impact of such programs, identification of the strengths and weaknesses of such programs, and evaluation of materials used in such programs.

(d) There is authorized to be appropriated $15,000,000 for the fiscal year ending June 30, 1976, $17,500,000 for the fiscal year ending September 30, 1977, and $20,000,000 for the fiscal year ending September 30, 1978, to carry out this section.

COMPREHENSIVE HEALTH EDUCATION PROGRAMS

SEC. 6. (a) The Commissioner may make grants to State educational agencies for the development of comprehensive programs in elementary and secondary schools with respect to health education and health problems. Such grants shall be available to State educational agencies for the development of such programs and for assistance to local educational agencies in the implementation of such programs.

(b) From the sums appropriated for carrying out this section for each fiscal year, the Commissioner shall reserve such amount, but not in excess of 3 per centum of such sums, as he may determine and shall apportion such amount among the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands according to their respective needs for assistance under this section. The Commissioner shall apportion the remainder of such funds as follows:

(1) he shall apportion 40 per centum of such remainder among the States in equal amounts; and

(2) he shall apportion to each State an amount which bears the same ratio to 60 per centum of such remainder as the number of public school children in the State bears to the number of public school children in all the States, as determined by the Commissioner on

the basis of the most recent satisfactory data available to him.

For purposes of this subsection, the term "State" does not include the Commonwealth of Puerto Rico, Guam, American Samoa, the Virgin Islands, and the Trust Territory of the Pacific Islands.

(c) The amount apportioned to any State under subsection (b) for any fiscal year which the Commissioner determines will not be utilized for such year shall be available for reapportionment from time to time, on such dates during such year as the Commissioner may fix, to other States in proportion to the amounts originally apportioned among those States under subsection (b) for such year, except that the proportionate amount for any of the other States shall be reduced to the extent it exceeds the sum the Commissioner estimates the local educational agencies of such State need and will be able to use for such year. The total of such reductions shall be similarly reapportioned among the States whose proportionate amounts were not so reduced.

(d) (1) Any State educational agency receiving a grant under this section shall, to the extent consistent with the number of children in the State involved who are enrolled in private elementary and secondary schools, make provision for including special educational services and arrangements (in-

cluding dual enrollment, educational radio and television, and mobile educational service and equipment) in which such children may participate.

(2) If the Commissioner determines that a State educational agency is unable or unwilling to comply with paragraph (1), he may make special arrangements with other public or nonprofit private agencies to carry out paragraph (1). For such purpose the Commissioner may set aside on an equitable basis and use all or part of the maximum total of grants available to the State involved.

(e) There is authorized to be appropriated $50,000,000 for the fiscal year ending September 30, 1978, to carry out this section.

GRANT REQUIREMENTS

SEC. 7. (a) Grants under this Act may be made only upon application at such time or times, in such manner, and containing or accompanied by such information as the Commissioner deems necessary, and only if such application—

(1) provides that the activities and services for which assistance under this Act is sought will be administered by or under the supervision of the applicant;

(2) provides for carrying out one or more projects or programs eligible for assistance under this Act and provides for such methods of administration as are neces-

sary for the proper and efficient operation of such projects or programs;

(3) sets forth policies and procedures which assure that Federal funds made available under this Act for any fiscal year will be so used as to supplement and, to the extent practicable, increase the level of funds that would, in the absence of such Federal funds, be made available by the applicant to carry out the purpose of this Act, and in no case supplant such funds; and

(4) provides for making such reports, in such form and containing such information, as the Commissioner may reasonably require, and for keeping such records and for affording such access thereto as the Commissioner may find necessary to insure the correctness and verification of such reports.

(b) (1) Applications from local educational agencies for financial assistance under this Act may be approved by the Commissioner only if the State educational agency has been notified of the application and been given the opportunity to offer recommendations.

(2) Amendments of applications shall, except as the Commissioner may otherwise provide by rule, be subject to approval in the manner provided by paragraph (1).

TECHNICAL ASSISTANCE

SEC. 8. The Commissioner shall, when requested, render technical assistance to local educational agencies, public and private nonprofit organizations, and institutions of higher education in the development and implementation of education programs with respect to health and health problems. Such technical assistance may, among other activities, include making available to such agencies or institutions information regarding effective methods of carrying out such programs, disseminating to such agencies or institutions information obtained through programs established by this Act, and making available to such agencies or institutions personnel of the Department of Health, Education, and Welfare, or other persons qualified to advise and assist in carrying out such programs.

PAYMENTS

SEC. 9. Payments under this Act may be made in installments and in advance or by way of reimbursement, with necessary adjustments on account of overpayments or underpayments.

ADMINISTRATION

SEC. 10. In administering the provisions of this Act, the Commissioner is authorized to utilize the services and facilities of any agency of the Federal Government and of

any other public or private nonprofit agency or institution in accordance with appropriate agreements, and to pay for such services either in advance or by way of reimbursement, as may be agreed upon.

Mr. MEEDS. First of all, I want to take the opportunity to thank all of the witnesses who are making this last minute shift in plans, which was made necessary this morning by the Democratic Caucus on the subject of Cambodia.

These hearings, and the timing of the hearings was set to coincide with the National PTA Legislative Conference for a very special reason.

I would like to welcome all of you from the PTA group this morning. The fact is that we most likely would not be here discussing this legislation, if it were not for the concern and hard work of the PTA, particularly Ms. Baisinger, the PTA legislative chairman, who has been with us on this legislation from the outset.

We very much appreciate the PTA's abiding concern and aid. That is not to say that many of the other organizations, particularly health organizations have not been equally strongly involved, and we also appreciate their help.

Let me be brief, and leave as much time as possible for the witnesses.

Senator Clark and I—Senator Clark, who will be our first witness this morning, first introduced this legislation in February of 1974, after working with the PTA, health education specialists, and others who were equally interested in upgrading the quantity and quality of health education.

The bill took the backburner last year, due to prior legislative commitments. However, this year, we really hope to move this legislation along. The bill would set up a 3-year program of teacher training, demonstration projects to develop, disseminate, and evaluate health education curriculums, and in the final year of the bill, it would provide direct grants to State and local agencies to start programs.

The full range of health programs is included: dental health, disease control, environmental health, family life, and human development, nutrition safety and accident prevention, smoking and health, consumer health, and venereal disease.

The bill accepts health as a unified concept, and health education as affecting the total human being. We are looking for ways to maximize the unique opportunity provided by the K–12 school system in this country.

Schools should play a vigorous and vital role in helping young people to develop, maintain, and protect their health, not by a piecemeal, bandwagon approach, but by planned, sequential curriculums taught by specifically trained teachers.

Senator Dick Clark of Iowa, our colleague from the Senate side, who has worked tirelessly on this legislation is our first witness this morning.

Dick, we are delighted to welcome you to the other body, and please proceed.

STATEMENT OF SENATOR DICK CLARK (IOWA)

Mr. CLARK. Than you very much, Mr. Chairman, and members of the subcommittee. On behalf of educators, health experts and concerned parents throughout the Nation, I particularly want to thank

you for your leadership in conducting these hearings on the subject of health education.

I know that you have many witnesses to hear today, and I will keep my remarks very brief, but it is a pleasure and an honor to participate in these hearings on the first anniversary of our introduction of this legislation, and I sincerely hope our activities today and tomorrow will pave the way for its enactment as quickly as possible.

You have outlined the bill very clear. So, just let me repeat some facts that I know, and I know you know, and that members of this subcommittee may know, several years ago the President's Committee on Health Education criticized the absence of a comprehensive program of health education and preventive health habits in this country.

The committee's report noted that of the $75 billion Americans spend annually on health care, about 93 percent goes for the treatment of illness, 5 percent for research, nearly 2 percent for prevention, and just one-half of 1 percent for health education.

These figures indicate that despite skyrocketing medical costs, we seem to forget the old adage that an ounce of prevention is worth a pound of cure where health care is concerned.

This is particularly shocking when we realize that the importance of preventive health care is not limited to simple economics. After all, the health of our people is the most crucial factor in the quality and enjoyment of life itself.

The President's committee particularly stressed that both the quantity and quality of elementary school health education are seriously deficient. A conclusion which means that children receive precious little in the way of helpful information in their first 10 years of life about forming lifelong habits of proper health care.

In light of that conclusion, it is not surprising that almost every child in this country suffers from tooth decay. Obesity, protein and vitamin deficiencies, and increased susceptibility to heart disease also are related to the sugar-rich diets consumed by too many of our citizens.

Either because of a lack of knowledge, a lack of time, or a lack of money, the majority of parents are unable to offset the harmful habits developed from the thousands of commercials that bombard children. For similar reasons, the educational system has failed to counteract these habits.

Mr. Chairman, the record of the Federal Government in response to this problem is abysmal. It is time that we close this gap immediately to take a positive step toward improving the quality of life in this country.

That is why I was pleased to introduce S. 544, the companion health education bill in the Senate. As you know, the bill would establish a 3-year program to encourage the development of sound health habits in children.

The goal would be accomplished by providing three kinds of grants: For teacher training, pilot and demonstration projects, and comprehensive school programs for health education. The bill authorizes a total of $140 million for these programs.

It is sound legislation with widespread support, including 8 Senators, and more than 50 Congressmen. I might mention that the Senators who are cosponsoring this legislation are Senator Harrison William, the chairman of the Full Committee on Labor and Public Welfare, Senator Hartke, Senator Humphrey, Senator Inouye, Senator Kennedy, Senator McGovern, and Senator Montoya. We hope to have additional sponsors in the near future.

Other supporters of the bill are such experts as the National PTA, the National Education Association, the American Association of School Administrators, the Council of Chief State School Officers, the National Association of State Boards of Education, and the National School Boards Association.

It is a comprehensive measure, which I think is long overdue. I hope the committee will take prompt and affirmative action on it.

Thank you for allowing me to testify here this morning.

Mr. MEEDS. Thank you very much.

I would first like to call upon, and to acknowledge the presence of the chairman of the full Education and Labor Committee, the Honorable Carl Perkins of Kentucky.

Chairman PERKINS. First let me compliment my colleague, Lloyd Meeds, on being the chief sponsor of this legislation in the House of Representatives. Lloyd produced this bill in previous congresses, I don't remember how many back, but as he has stated the time is now right for such legislation to become law, at least for this body and the other body.

We hope that the President of the United States will approve this type of legislation in the primary and secondary schools. In my judgment, in the long-run we will save all levels of government money, if we can prevent some diseases from occurring by the right type of a comprehensive health program at the elementary and secondary level.

I am pleased to be one of the cosponsors with the gentleman from Washington, and the other members of the subcommittee. I want to congratulate Senator Clark for his tremendous leadership in sponsoring such an important piece of legislation in the U.S. Senate.

I want to assure Mr. Meeds, who is going to conduct these hearings, that we will not waste any time before the full committee in marking up the legislation. Just as soon as he completes the hearings before the subcommittee, we are going to approve the bill.

I think that it behooves us all to take our hats off to Mr. Meeds for taking such a progressive step forward at this time, in such an important area.

There is no need for me to say anything further, or question the witnesses. Mr. Meeds and I have discussed the importance of this subject matter on numerous occasions, so I will go and get a few things done before we have the caucus this morning. The bill is in good hands, and that is all I have to say.

Mr. MEEDS. Thank you very much, Mr. Chairman.

I have no questions. I would like, however, to take the opportunity to thank and commend my colleague from Iowa, Senator Clark, for his leadership in the other body for this very important

legislation, and to assure the people who are equally interested in the passage of this legislation, that it is, indeed, fortunate legislation that has champions on both sides of the Hill.

We expect that we will move rapidly with the legislation and hope that the other body will as well. We know that it is in good hands on the Senate side. I thank you for your participation, Dick.

The gentleman from Iowa, Mr. Blouin.

Mr. BLOUIN. Thank you, Mr. Chairman.

I thought it would be appropriate if I thanked not only my Senator, but my constituent, for the time he has put in, and the dedication he has shown to the passage of this legislation.

As one who taught at the fifth grade level not too many years ago, I know of what you speak. I am convinced that there is a tremendous amount of educational work that can be done at the lower grade level all the way through the high school completion level.

I would be very honored if this subcommittee could get the ball rolling as rapidly as possible, and move this legislation on its way.

Mr. MEEDS. Thank you very much.

The gentlemen from Ohio, Mr. Mottl.

Mr. MOTTL. I have no questions, Mr. Chairman. The Senator has made a very nice presentation. Let us move the bill.

Mr. MEEDS. The gentleman from Illinois, Mr. Hall.

Mr. HALL. I would just add a ditto.

Mr. MEEDS. We have nothing but plaudits for you, no questions.

Mr. CLARK. I was delighted to hear Chairman Perkins comments. That reveals the kind of interest that your subcommittee has shown and the guidance that it has been giving. I appreciate very much this opportunity of being with you.

Mr. MEEDS. Thank you, Dick.

Our next witness this morning is Mrs. Herndon, who is president of the National PTA. Mrs. Herndon, please come forward.

Let me first, on behalf of the subcommittee and the full committee, and myself personally, thank you for your leadership in helping us with this legislation Also, we hope that you have a good national conference here. We are delighted to be able to have these hearings to coincide with the timing of this conference.

I see that you have a prepared statement. If you like, you may read it into the record, or proceed to summarize it, whichever you wish.

STATEMENT OF MS. LILLY E. HERNDON, PRESIDENT, NATIONAL CONGRESS OF PARENTS AND TEACHERS

Ms. HERNDON. Thank you very much, Mr. Chairman, and subcommittee members I am Lilly Herndon, president of the National PTA, and I am from South Carolina.

The PTA is very grateful to the committee for scheduling the beginning of the hearings on the Comprehensive School Health Education Act while our legislative conference is meeting in Washington.

We have representatives here from the European PTA, Alaska, Hawaii, and about 43 of the PTA's on the mainland here. So, we are delighted to be able to participate in these hearings.

The National PTA, as you know, is an organization of approximately 7 million members, with memberships in every State, the European PTA and the District of Columbia. We have PTA's in approximately 45,000 local communities in the Nation.

The National PTA is concerned about the health of our children, who become adults and parents. This is a major concern to us.

As far back as our very first convention in 1897, 5 of the 23 papers presented there were devoted to the problem of health. They covered dietetics, diabetes, physical development, reproduction, and heredity.

National PTA's critical role in the enactment of the national school lunch program is well known throughout the Nation. PTA volunteers served hot soup and cocoa to school children. Good health for these children was the object, and a roushing school lunch was one way to health.

However, we believe that it is simply not enough to feed children. Children and youth must be given the opportunity to understand why a nutritionally balanced meal is important. Yet, nutrition education to help our young people understand intellectually as well as emotionally the relationship of food to one's physical and mental well-being is conspicuously absent from the health education programs in our elementary schools; limited and not always available to students in the secondary schools.

In a recent survey, an elementary classroom teacher in Prince George's County, Md., told us that the Washington Post and the Washington Star do a better job in nutrition education than the schools.

So, it is any wonder that Americans of all ages, and economic status suffer from malnutrition, tooth decay, obesity and protein and vitamin deficiencies, and for future mothers, the consequences can be rather devastating for her baby.

A need for a coordinated and systematic approach to health education that encompasses not only informational and cognitive data, but focuses also on such vital areas in health teaching as values clarification, peer pressure, problem solving and decisionmaking, has been long apparent, and we are now directing our efforts toward attaining this objective.

As has been pointed out many times, it is ironic, indeed, that in a society that has developed the scientific knowledge to eliminate many of the health problems that plague us, we have not yet created an attitude in our population to want good health.

Senator Clark has just mentioned to you that we are only spending 2 percent on prevention, and one-half of 1 percent on health education of the $75 billion that we spend on health care.

As Victor Hugo once wrote, no army can withstand an idea whose time has come. We believe that comprehensive school health education is an idea whose time has come. if not for humanitarian needs, then certainly for economic reasons.

No longer can this country afford the luxury of allowing its young people to grow up ignorant or indifferent to their health needs.

The high incidence in our society of emotional illness, veneral disease, drug abuse, alcoholism, emphysema, to name only a few diseases that can be prevented, is a real cause for concern, not only in

human terms, but in terms of the economic health and productivity of our society.

Through comprehensive school health education, PTA believes it can create an awareness and a desire on the part of children and youth to want good health We are convinced that this is the only way in which a lasting and meaningful program in prevention can work.

To this end, as far back as 1970, the National PTA, along with the other members of the big six—the American Association of School Administrators, Council of Chief State School Officers, National Association of State Boards of Education, National Education Association, and the National School Boards Association—adopted the position that urged that Federal legislation give support to a comprehensive K through 12 school health education program.

We know from the report of the President's Committee on Health Education in 1971 that 59 million schoolchildren then enrolled in elementary and secondary schools have no opportunity to participate in comprehensive school health education programs. For these children, there is no health education, or it is lacking in scope, sequence, and commitment of time, money, and administrative supprt.

In 1974, the PTA did its own survey, and found that the situation had not changed. Admittedly, Mr. Chairman, the PTA survey was not scientifically designed nor administered. However, we feel perfectly justified in asserting that the results are representative of what is happening, or more aptly put, what is not happening in health education in our country today.

We asked six brief questions in the survey that went out to parents, teachers, students, and administrators in school systems throughout the country. We asked them: (1) When does education begin in your school? (2) What is being taught? (3) By whom is it taught? (4) How is it taught? (5) What do you believe is lacking in the health education being given in your school? (6) How would you suggest school health education be improved?

If I might give you a few of the answers that we received on question No. 5, which said: "What do you believe is lacking in the health education being given in your school?"

From Central Valley, Calif.: "Plenty. Not starting early enough."

From Culver City, Calif.: "Dollars."

From Fulton County, Ga.: "Continuity and mandatory inclusion."

From Minnesota: "There is a definite lack of a coordinated health education program, K through 12; there is a need for inservice education of the elementary school classroom teacher. There is also a need for curriculum development."

From Pennsylvania: "I think we could use programs in family life, value clarification and environmental health."

From Washington: "Teachers are not committed to the program due to lack of training."

Mr. Chairman, I could go on and on giving replies, which we received, which are in the prepared testimony, but there is not time for that I would like to say of the 500 responses we received, only 4 respondents said that there is nothing lacking in their school health education program.

I think that we could summarize our survey in two sentences, by saying: There is no comprehensive school health education in this country, even in the few States where such programs have been adopted, implementation is indifferent or lacking. It is lacking because of the lack of qualified teachers, materials, and money. There are wide differences in the quality and quantity of health education in schools among the States, within the States, and even within the single school district.

Now, nowhere was there a unified, sequential approach to health education. There is great need for curriculum material and materials that are up to date, factual, and realistic for today's world.

The National PTA's survey does indicate to us that with additional resources, the greatest improvement in school health education could be made at the elementary level. National PTA is not suggesting that we try to make all elementary school teachers health educators, or that every school district begin immediately to hire a health educator for each building.

Rather the National PTA's objective is to provide better college and university preparation for classroom teachers in the area of health education, so that when these teachers enter the classroom they will have a greater knowledge of, and appreciation for, school health education.

Such teachers, we believe, would be more apt to look for resource help that is available to them from home economists, school nurses, and physicians, just to cite a few. We view the health educator as the primary resource for the elementary classroom teacher; responsible for developing curricula and instructional material; and fully certified.

Coordinating health education for every school district should be a fully qualified health educator.

We see the Comprehensive School Health Education Act as the vehicle for upgrading the profession of the health educator. Funds authorized in phase I would help provide the necessary academic upgrading for these specialists through inservice training.

Phase II would permit State departments of education and local school districts to try new approaches and programs heretofore impossible because of the lack of funds.

National PTA has made enactment of the Comprehensive School Health Education Act one of its top five legislative priority items for 1974–75.

Mr. Chairman, and committee members, we want to assure you that we shall follow the progress of this legislation very closely. We do thank you for the opportunity to be heard here today.

Mr. MEEDS. Thank you very much, Ms. Herndon .

The ranking minority member, Mr. Quie, had to leave. He has asked the opportunity to have some questions asked.

Again, my thanks for all of your help, and my commendations on this excellent testimony.

Unless there is objection, the full written statement will be printed in the record, and your summary will follow that.

[Prepared statement of Lilly E. Herndon follows:]

PREPARED STATEMENT OF LILLIE E. HERNDON, PRESIDENT, NATIONAL CONGRESS OF PARENTS AND TEACHERS, CHICAGO, ILL.

I am Mrs. Lillie E. Herndon, of Columbia, South Carolina, president of the National PTA.

The PTA is deeply grateful to the Committee for beginning hearings on the Comprehensive School Health Education Act at the time PTA delegates from throughout the country are attending the National PTA legislation conference in Washington, D.C.

National PTA is an organization of 7½ million members from every state, the District of Columbia, and the European Congress of American Parents, Teachers, and Students. In 1949, Harry and Bonaro Overstreet made a study of the PTA and its influence on education and social growth in the United States. They titled their book: *Where Children Come First.* The Overstreets wrote: "We believe that what the National Congress of Parents and Teachers has been doing is the sort of thing that must be done by more and more groups if our culture is to maintain its integrity."

The words of the Overstreets still describe the purpose of PTA. Children and their welfare are our prime concern.

The health of children, who become adults and parents, is of major concern to PTA. As far back as the first convention in 1897, five of the twenty-three papers presented were devoted to the problems of health. They covered dietetics, diabetes, physical development, reproduction and heredity.

In 1925, PTA began the Summer Round Up of Children. PTA members canvassed their neighborhoods to locate children who were to enter school in the fall to ensure that they received a medical and dental examination. The need for a child to be in good physical condition upon entering school was emphasized. The Summer Round Up proved to be a dramatic way to bring the health of children to the attention of parents, teachers, and health authorities. Today, health examinations are part of community/school services, overtaxed and indifferent in some instances, but, nevertheless, an accepted part of a child's school life.

National PTA's critical role in the enactment of the National School Lunch Program is well known. PTA volunteers served hot soup and cocoa to school children. Good health for these children was the object. And, a nourishing school lunch was one way to health. It is not enough, however, simply to feed children. Children and youth must be given the opportunity to understand why a nutritionally balanced meal is important.

Yet nutrition education to help our young people understand intellectually, as well as emotionally, the relationship of food to one's physical and mental well being is conspicuously absent from the health education programs in our elementary schools; limited and not always available to students in the secondary schools. In a recent survey, an elementary classroom teacher in Prince George's County, Maryland told us that the *Washington Post* and the *Washington Star* do a better job in nutrition education than the schools.

As we have failed to provide education about the value and importance of nutrition, is it any wonder, then, that the charges of waste and decreasing student participation in the National School Lunch Program are fully substantiated. We even accelerate this "pushout" by allowing vending machines to dispense carbonated beverages and sugar ladened foods, often in competition with the lunch program. It is no wonder that Americans of all ages and economic status suffer from malnutrition, tooth decay, obesity, and protein and vitamin deficiencies. For the future mother, the consequences can be rather devastating for her baby.

Although PTA has supported such categorical health education programs as drug abuse education, parent and family life education, education about venereal disease, and many others, as the attached PTA Health Milestones and convention resolutions indicate, the need for a continuous, coordinated, and systematic approach to health education that encompasses not only informational and cognitive data, but focuses also on such vital areas in health teaching as values clarification, peer pressure, problem solving and decision making, has long been apparent, and PTA now is directing its efforts toward attaining this objective.

As has been pointed out many times, it is ironic, indeed, that in a society that has developed the scientific knowledge to eliminate many of the health problems that plague us, we have not yet created an attitude in our popula-

tion to want good health. Instead, we are willing to spend $75 billion on health care, 93 percent of which goes for treatment of illness, and only 2 percent is spent on prevention, and one-half of one percent on health education.

As Victor Hugo once wrote, no army can withstand an idea whose time has come. We believe comprehensive school health education is an idea whose time has come, if not for humanitarian reasons, then certainly for economic reasons. No longer can this country afford the luxury of allowing its young people to grow up ignorant and/or indifferent to their health needs. The rising incidence in our society of emotional illness, venereal disease, drug abuse, alcoholism, emphysema, to name only a few diseases that can be prevented, is a real cause for concern, not only in human terms, but in terms of the economic health and productivity of our society.

We are increasingly looking to the federal government to assume the burden of health care, as well as its soaring cost. To the extent that we can help people through preventive health education maintain their health without consulting health professionals, or to utilize the services of health care professionals more effectively, the cost of health care will be correspondingly reduced. Through comprehensive school health education, PTA believes we can create an awareness and a desire on the part of children and youth to want good health. We are convinced that this is the only way in which a lasting and meaningful program in prevention can work.

To this end, in 1970, the National PTA, along with other members of the Big Six—American Association of School Administrators, Council of Chief State School Officers, National Association of State Boards of Education, National Education Association, and National School Boards Association—adopted the following position statement: "We urge that federal legislation give support to a comprehensive (K-12) health education program that will combine needed attention to such health problems as alcohol and drug abuse, smoking and health, physical fitness, mental health, family life and human development, human ecology, the need for continuous health supervision, venereal disease, nutrition, accident prevention, and consumer education. We urge provision for inservice and preservice teacher education, updated teaching materials, and other factors in strengthening a comprehensive health instruction program. We further urge the Congress, the Secretary of Health, Education, and Welfare, and the U.S. Commissioner of Education to establish a higher federal priority for this program."

The Report of the President's Committee on Health Education in 1971 found that most of the 59 million children then enrolled in elementary and secondary schools have no opportunity to participate in comprehensive school health education programs. For these children, there is either no health education or it is lacking in scope, sequence and commitment of time, money, and administrative support.

A survey taken by the PTA in the summer of 1974 found the situation had not changed. Admittedly, the PTA survey was not scientifically designed or administered. However, we feel perfectly justified in asserting that the results are representative of what is happening—or more aptly put, what is not happening—in health education in our country today.

Parents, teachers, students, and administrators in school systems throughout the country were asked to respond to the following six questions:

1. When does health education begin in your school?
2. What is being taught?
3. By whom is it taught?
4. How is it taught?
5. What do you believe is lacking in the health education being given in your school?
6. How would you suggest school health education be improved?

Respondents were instructed not to submit as their responses formal guidelines or objectives for school health education developed by their school districts or state departments of education. Rather, National PTA wanted to hear "in your own words what your schools are offering in the way of health education" or to put it in the popular vernacular, we asked respondents "to tell it like it is."

Questionnaires were returned from all parts of the country and included responses from parents, teachers, students, and administrators. A majority of the responses were reports on health programs in the elementary schools.

Before presenting a summary of the results, let us quote a few of the individual responses to question 5: What do you believe is lacking in the health education being given in your school?

Central Valley, Calif.—Plenty. Not starting early enough.

Culver City, Calif.—$ $ $.

Fulton County, Ga.—Continuity and mandatory inclusion.

Louisville, Ky.—Not enough time given on individual health habits and not enough time teaching proper nutrition.

Minnesota—There is a definite lack of a coordinated health education program, K-12; there is a need for inservice education of the elementary school classroom teacher. There is also a need for curriculum development.

Lubbock, Tex.—I personally feel a whole lot is lacking, especially since we don't have health education classes.

Mountaintop, Pa.—I think we could use programs in family life, value clarification and environmental health.

Traverse City, Mich.—Social diseases aren't covered at all. Another respondent said there wasn't any health education as far as she knew! There was no continuity, no model, no guidelines, said another respondent.

Kent School District, Wash.—Teachers are not committed to the program due to lack of training.

South Dakota—There are no colleges in state with training programs in health education. Need College courses by qualified teachers.

Cincinnati, Ohio.—More family living education is necessary.

White County, Tenn.—It is readily apparent that the program in White County is a typical fragmented approach to health education. As such, it is probably typical of programs in all rural areas of the state.

Ossining, New York—Schools with "upper class" kids with fewer reading and math problems seemed to find a bit more time for health than the Title I schools. (Those who probably need more health education get least!) . . . There seems to be a lack of suitable materials.

St. Louis, Mo.—Everyone worries about the child who eats no breakfast, but no one gets too excited about the child who has Kool-Aid and a Twinkle . . . it is this last child who often comes from the so called 'good' home . . . I teach health to sixty five year olds each day in some way, but I am not sure it is adequate . . . So while my desire is mainly for the children to be educated in this area, as a teacher, I, too, need all the help I can get.

Students attending Texas Tech University, Lubbock, Texas wrote:

When I was in high school, there was no health education whatsoever. The physical education class substituted for the health, and even they consisted not of education, but of athletics. At the time that was fine, but I now see how sad the situation really is. The areas of venereal disease, pregnancy . . . were never mentioned in any setting. I would like so much to see this changed not only in my old high school, but in all of those in Texas—Sandy Gilbert.

The first time I had any health education was in the seventh grade and we had three days of health out of a whole year of physical education—Paula Miller.

In the school I attended, health was introduced in the second or third grade, but I have no recall of what was taught . . . [In high school] I did not receive information of many health oriented items that I should have long before I was a sophomore . . . [Health] was taught by a physical education teacher . . . These students need so bad to be taught prevention as well as being able to recognize warning signs of diseases. A lot of lifes (sic) could be saved if people were more informed in the area of health—Sherry Green.

Parenthetically, we might add to Sherry Green's comment that it was shocking to learn from a recent survey made by the Virginia State Health Department that although 98 percent of 2-year olds in the state received their first immunization shots for communicable diseases, only 53 percent of these toddlers received their second shots. We conclude, obviously, that the importance of health care to prevent disease has not been fully accepted by our young parents as immunization shots can be obtained without charge for those in economic need.

A San Antonio, Texas teacher wrote: Health Education begins at the sixth grade level . . . and the classes are segregated by sex and taught by physical education majors . . . They do not have certification in Health . . . I personally feel that the school needs more important areas covered such as: Cancer,

obesity, Sex Education, and Alcohol. I also feel that the administration should add an additional six weeks period for health education . . . My first suggestion would be a certification for school health educators. An additional suggestion would be that Government help sponsor more funded programs and also help improve the curriculum that is now being used in most public schools.

In a detailed communication, a parent from Noble, Oklahoma wrote: Rural school systems should be constantly up-dated with health education studies. Students are maturing more rapidly . . . than some parents want to admit. These students need to be informed . . . Teachers need to take courses to better qualify their teaching such matters.

Sharon Dykstra of Lubbock, Texas, a student, stated: There was supposed to be 1 semester of government and 1 of health. The elementary principle (sic) taught both. He decided he needed more time for government and allowed only the last few weeks for health. Then all we did was answer questions at the end of the book during class. The book wasn't very current and seemed geared to the junior high level. It left much to be desired in helping to solve health problems

Of the 500 responses received, only 4 respondents said there was "nothing lacking in their school health education programs"

Responses to the six questions posed by the National PTA could be summed up as follows:

There is no comprehensive school health education in this country. Even in the few states where such programs have been adopted, implementation is indifferent or lacking due to: lack of qualified teachers, materials, and money. There are wide differences in the quality and quantity of health education in the schools among the states, within a state, and even within a single school district. No where was there a unified, sequential approach to health education fully implemented.

Health education in the elementary grades is hit and miss at best, dependent upon the interests and ability of the classroom teacher. In many instances, overburdened school nurses are asked to assume what they can of the health education program.

There is a need for curriculum materials—materials that are up to date, factual and realistic for today's world.

There are serious omissions in what is covered under health education in the schools. Dental health would seem to be the one area that is receiving reasonably good attention, yet the results here are mitigated by the lack of nutrition education. Children still suffer from unnecessary dental caries.

Family life and human development, mental health, emotional health, environmental and consumer education are rather conspicuously missing or lacking in most schools. There appears to be an inability to integrate the physical aspects of growth and development with the emotional needs of students, particularly for high school students.

There is no significant nutrition education in the elementary schools, and very little in the secondary schools because nutrition education is limited to home economics classes which, we know, are not required of all students.

With additional resources, the greatest improvement in school health education could be made at the elementary level. At the present time, unprepared elementary school teachers are carrying the burden, in too many instancs, for whatever health education is given. As a result of poor preparation, many teachers avoid health education. There is evidence, too, that even health educators are poorly prepared.

Briefly, we would like to report the results of the survey of the public schools of Santa Clara, California, made by the school health coordinator in cooperation with the County Office of Education. The Sixth District of the California Congress of Parents and Teachers provided the mechanism by which a resident of each district with particular interests in health was contacted, and their services obtained to conduct interviews with the superintendents of the various school districts. These volunteers were involved in an orientation session that acquainted them with the survey instrument and how to carry out the interviews. Of 33 school districts, information was returned from 30, representing 402 schools out of the 414 in the County.

An individual school may have a nurse responsible for its health services, possibly in conjunction with a health secretary or aide. However, the survey results indicated that the schools in this country generally have professional

nursing coverage on an average of about 20 percent of the time (ranging from 5% to 100%).

Approximately ⅓ of the districts indicated the presence of one or more full or part-time staff with an educational background in health education (almost entirely at the high school level). Science teachers, however, were primarily identified as the staff responsible for health education at the secondary level. At the elementary level, the school nurse was usually listed as the health education resource to the classroom teacher. In most schools (with the exception of those few schools active in the Berkeley Health Project) the health taught—if, when, what, and how much, was the individual classroom teacher's decision.

In relation to the specific health education occuring within the schools, the variety in terms of what and how much is taught is so great, I am unable to generalize it into any reasonable summary. Examples of replies to the question on the type of health education program offered, range from none, "does not apply", "very little", "spasmodic", "extremely variable—depends on teacher's interests", "program development in progress", "based on screening", "all that's necessary", to indications (at least on paper) of very comprehensive coverage of the whole health field.

The type of assistance schools indicated a desire to have from this Department spanned the entire spectrum (from mobile immunization clinic services to the developing of complete health education units for teachers). Items such as posters, AV materials, and speakers were identified as desirable in most all health areas, but with an increased emphasis placed on Family Health, Drugs, and Mental Health. However, Nutrition, Environmental Health, and Venereal Diseases were also high interest topic areas where support would be welcome. A very common request was the need to be able to receive larger supplies of pamphlets (such as on venereal diseases which in some schools is the only written material on this topic allowed to be used). In-service training and consultation for teachers in all of the above areas as well as on other health topics was also indicated as desirable.

In summary, the results of this initial survey were as follows: (1) Health is a relatively low priority in most schools; (2) Health services and health education programs are generally minimal and somewhat haphazard in their implementation; and (3) Support in most any form from community health resources would be welcome and is vitally needed.

The similarities in the conclusions reached in the National PTA survey and the Santa Clara, California survey are readily apparent.

Although the National PTA survey indicates that, with additional resources, the greatest improvement in school health education could be made at the elementary level, National PTA is not suggesting that we try to make all elementary school teachers health educators, or that every school district begin immediately to hire a health educator for each building.

Rather, the PTA objective is to provide better college and university preparation for classroom teachers in the area of health education so that these teachers, upon entering the classroom, will have a greater knowledge of, and appreciation for, health education. Such teachers would be more apt to look to the resource help that is available to them from home economists, school nurses, and physicians, to cite just a few samples. We view the health educator as the primary resource, and consultant, for the elementary classroom teacher; responsible for developing curricula and instructional materials; and fully certified. Coordinating health education for every school district should be a fully qualified health educator.

We see the Comprehensive School Health Education Act as the vehicle for upgrading the profession of the health educator. Funds authorized in Phase I for preservice and inservice training would help provide the necessary academic upgrading for these specialists as well as the classroom teacher. Phase II would permit state departments of education and local school districts to try new approaches and programs heretofore impossible because of a lack of funds. Curriculum development is time consuming and staff members cannot find the additional time to develop K-12 guidelines. Help from the federal government would also serve as an impteus for state and local school districts to adopt comprehensive school health education programs. We are pleased to note, too, that the focus of the proposed legislation is on instruction rather than the delivery of services.

We cannot close this testimony without some reference to the need to motivate the general public to want good health. While it is true that if we concentrate on children, adults will learn soon enough from them (witness how adults picked up the music and dress of the teens!), as we launch the Comprehensive School Health Education Act, we would hope that there could be a concerted effort to educate parents and the public in general on how to prevent illness and promote positive health practices. This is not to suggest that the legislation now under consideration be amended to make the private sector or agencies other than educational institutions eligible for grants for this purpose. We believe the decision to limit the eligibility for grants to the education community is a wise one. Given limited funds, let us leave this effort to upgrade the teaching of health in the schools to the education community.

We can, however, with other resources, build public support for a comprehensive approach to school health education. A good beginning would be to develop a broad public awareness program in health education.

National PTA has made enactment of the Comprehensive School Health Education Act one of its top five Legislative Priority Items for 1974–75. We shall, you may be sure, follow the progress of this legislation closely.

We thank you for this opportunity to be heard.

NATIONAL CONGRESS OF PARENTS AND TEACHERS, RESOLUTION

Adopted by the 1973 Convention of the National PTA

COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM

Whereas, The National PTA is vitally interested in the teaching of health in the public schools, and

Whereas, The school health curriculum has been fragmented into separate programs in such areas as drug abuse, venereal disease, environmental health, and family life education, and

Whereas, Many local school districts have combined health education and physical education programs, and

Whereas, There is a need for a comprehensive program of health instruction in our schools which will meet the total needs of all children and youth, therefore be it

Resolved, That the National PTA lend its full and active support to the development of an identifiable comprehensive school health education program to include dental health, disease control, environmental health, family life, mental health, nutrition, safety, and substance abuse, and that the National PTA reaffirm the 1970 position statement of the National PTA Board of Managers relating to Federal and State Support to Comprehensive School Health Education Programs* while giving wide publicity to the similar position statement adopted by the Big Six** (National Congress of Parents and Teachers, American Association of School Administrators, Council of Chief State School Officers, National Association of State Boards of Education, National Education Association, and National School Boards Association); and be is further

Resolved, That the National PTA urge its state branches to cooperate with their state departments of education and health, and with local school districts, to develop such a program.

PTA HEALTH MILESTONES

1897—Founding of the National Congress of Mothers, February 17, forerunner of the PTA. Scientific leaders of the day spoke on health.
1898—Convention advocated sex education before puberty and physical education in public schools.
1899—Petitioned Congress for a National Health Bureau (fourteen years before creation of U.S. Public Health Service).
1903—Committee on Delinquent, Defective, and Dependent Children formed. Needs of handicapped children studied.
1904—Published booklets on sex education and on state laws about dependent, handicapped, and delinquent children.
1906—Pure Food Bill, supported by PTA, became law.

1908—Supported movement to combat TB.
1909—Committee on Child Hygiene created and given support by advisory committee of nine physicians.
1910—Resolution endorsed instruction and care of mother before as well as after birth of the child.
1911—Convention voted to work for child hygiene departments in every board of health.
1912—PTA's sponsored hot lunches in many schools. Chinese women expressed appreciation for PTA moral support in efforts to abolish use of opium in China.
1914—Started campaign to arouse public interest in reducing infant mortality.
1920—Backed bill for universal physical education in public schools and recommended that every state establish schools for the deaf.
1925—Inaugurated nationwide health project, Summer Round-Up of the Children.
1926—Resolution urged action to eliminate smoking by minors.
1930—PTA president attended White House Conference on Child Health and Protection, which drew up Children's Charter.
1932—84,925 children examined through Summer Round-Up; 40,055 defects corrected.
1934—Participated in Conference on Child Health Recovery called by Secretary of Labor.
1936—Initiated traffic safety education project, with grant from Automotive Safety Foundation.
1938—Represented on National Committee for Better Care for Mothers and Babies. *PTA Magazine* article warned students against dangers of using "pep pills" to extend study time
1939—Represented on National Anti-Syphilis Committee.
1941—Inaugurated school lunch program on nationwide basis.
1946—Legislation for permanent federal school lunch program, long advocated by NCPT, enacted.
1948—Helped draft Local Public Health Services Act and sponsored its introduction in Congress.
1949—Supported Hoover report that led to creating U.S. Department of Health, Education, and Welfare.
1951—Conducted nationwide conference on narcotics and drug addiction.
1954—Promoted active participation in National Foundation for Infantile Paralysis field trial tests of vaccine to prevent polio.
1956—Set up program of continuous health supervision of children from birth through high school (extension of Summer Round-Up).
1961—Produced safety filmstrip *One To Grow On* in cooperation with Automotive Safety Foundation. Carried on pilot projects in continuous health supervision program in three states.
1963—Resolutions scored mass media advertising of tobacco and tobacco use by minors. Published *Keeping Children Healthy* as guide for PTA programs in continuous health supervision.
1964—Resolutions urged educating youth on hazards of smoking and strengthening programs to combat venereal disease. Published *Children's Emotional Health: A PTA Guide for Community Services.*
1965—Resolutions on control of stimulant and depressant drugs. Conducted pilot projects on children's emotional health in three states.
1966—Launched project on smoking and health, funded by U.S. Public Health Service.
1968—Launched nationwide project on children's emotional health, funded by National Institute of Mental Health.
1969—Held three regional conferences on smoking and health. Produced TV spot on smoking and health. NCPT president assisted in planning White House Conference on Food, Nutrition, and Health.
1970—Resolution urged that environmental education programs be developed and included in the curriculum from preschool through college.
1971—Established Commission on Health and Welfare as one of five commissions of National PTA Board of Managers. Supported legislation for free or reduced-price lunches for all needy schoolchildren (bill passed) and for VD and drug control.

NATIONAL CONGRESS OF PARENTS AND TEACHERS

SEX EDUCATION IN THE SCHOOLS

(Resolution Adopted by the 1969 Convention Delegates)

Whereas, The PTA has expressed the belief that sound education about family life and sex education is basic if children are to understand human development, cope with the stresses and pressure of adolescence in modern America, and become adults capable of successful marriage and responsible parenthood; and

Whereas, The goal of sex education, we believe, is to develop responsibility in human relations—relations between boys and girls, husband and wife, parents and children; and

Whereas, Many parents, although they acknowledge that ideally sex education should be carried on in the home, may be inadequately prepared to provide it; be it therefore

Resolved, That the NCPT urge its members to support state departments of education in the preparation of suitable instructional materials that will assist school districts in giving proper emphasis and balance to the emotional, physical, ethical, and social responsibilites in sex education as a part of a sound curriculum; and be it further

Resolved, That superintendents, principals, teachers, and school board members be urged to work with local advisory committees consisting of parents, religious leaders, physicians, and qualified representatives of community agencies in developing their own school programs of sex education, selecting instructional materials, and making certain that teachers in these programs have been prepared for their important responsibility; and be it further

Resolved, That the recommendations contained in the National PTA President's Message entitled "The Case for Sex Education," in the May 1969 issue of *The PTA Magazine*, receive wide distribution.

NATIONAL CONGRESS OF PARENTS AND TEACHERS

EDUCATION ABOUT VENEREAL DISEASE

(Adopted by the 1966 Convention Delegates)

Whereas, Venereal disease is one of the greatest public health problems facing the people of the United States today, and has constituted an increasing threat to the health of our young people;

Whereas, These diseases strike without regard to age, sex, race, wealth, status, or geography;

Whereas, Techniques are available to eradicate syphilis from the United States by 1972, and to control the spread of gonorrhea until effective tools can be developed to eradicate that disease;

Whereas, There is an acute need for universal education of our population about these diseases; now, therefore be it

Resolved, That the National Congress of Parent and Teachers go on record as endorsing the introduction of a sound and adequate program of venereal disease education into every school system in the United States, beginning at least by the eighth grade; and be it further

Resolved, That the National Congress of Parents and Teachers recognize officially that no dread, crippling, incapacitating disease has any place or purpose in a civilized society; and be it further

Resolved, That the National Congress of Parents and Teachers urge parents, youth leaders, educators, and all other responsible citizens to lend their active support in every way possible to the eradication of syphilis from the United States by 1972, and to the control and eventual eradication of gonorrhea as well; and be it further

Resolved, That the National Congress of Parents and Teachers call upon the President of the United States and the members of the Congress of the United States to lend the prestige and power of their high offices to the accomplishment of these important goals.

NATIONAL CONGRESS OF PARENTS AND TEACHERS, STATEMENT ON THE CHILDREN'S DENTAL HEALTH ACT OF 1971

(By Mrs. Walter G. Kimmel, Coordinator of Legisiative Activity National PTA, July 15, 1971)

On behalf of National PTA, we appreciate this opportunity to express our long standing and continued concern for the general health of all children—including dental care. Our *PTA Manual*, directing the work of all local units, carries the following suggestion: "Work for the fluoridation of the local central water supply and for all other maens of reducing dental caries, including topical applications of fluoride, good nutrition, and regular dental checks."

Also, many years ago the Board of Managers of the National PTA adopted the following statement: "Since fluoridation of the water supply, one part in a million, has been shown to reduce dental decay by one half, PTA's should be encouraged to interest themselves in making this health measure available to the children in their communities." Probaby updated and improved statistics are now available on the effectiveness of fluoride. However, we are told that communities containing 57 percent of the nation's population do not have fluoridated water. Our support of fluoridation has remained strong through the years. We continue to urge our people to work for fluoridation in their own communities. Passage of this act would provide financial assistance to their efforts.

We are aware of the high rate of dental caries among children, and that dental defects and disease in children pose a substantial national health problem. The damage to the child's emotional health, due to dental neglect, is also of concern. Recently a juvenile court judge commented that it seemed to him the two most common factors among children in trouble were that they couldn't read and they had bad teeth. Admittedly, this doesn't prove anything, but it said something to him. Millions of children in this country need dental care—both preventive and corrective. It is not available to them—mainly for economic reasons. We sincerely hope that this situation can be changed through funding and the efforts of federal, state, local, and private agencies.

Thank you for receiving our views.

NATIONAL CONGRESS OF PARENTS AND TEACHERS, RESOLUTION

(Adopted by the 1974 National PTA Convention)

REAFFIRMATION OF IMPORTANCE OF MAINTAINING ENVIRONMENTAL QUALITY

Resolved, That in this period when the search for energy resources, population pressure, and air and water pollution threaten envorinmental quality, National PTA urge all PTA members to give renewed attention to the following resolutions adopted by previous conventions:

Programing for environmental quality (1972)

Whereas, The National PTA recognizes the critical nature of environmental problems and accepts the responsibility and opportunity to contribute significantly toward the solution of our environmental crisis; and

Whereas, The worldwide crisis in our physical environment is marked by the convening of the first United Nations Conference on the Human Environment in Stockholm, Sweden on June 5–17, 1972; be it therefore

Resolved, That the National PTA reaffirms its 1970 convention resolution, Environmental Quality and the PTA; and be it further

Resolved, That the National PTA and all its branches be urged to plan and maintain action programs to improve the quality of our physical environment.

Environmental quality and the PTA (1970)

Whereas, The effects of the population crisis, air and water pollution, and the loss of natural areas are threatening the ecological balance that makes our life systems possible; be it therefore

Resolved, That, in support of priority area #3 of the National Action Program, the National PTA, its state branches, and its local units initiate action designed to inform their members and the general public of the urgency of improving the quality of environment; and be it further

Resolved, That the National PTA, its state branches, and its local units urge that environmental educational programs be developed and included in the curriculum from prekindergarten through higher education.

NATIONAL CONGRESS OF PARENTS AND TEACHERS

PARENT AND FAMILY LIFE EDUCATION

(Resolution Adopted by the 1967 Convention Delegates)

Changes have come into our society that greatly influence the home, and changes have come in the lives of children and youth that have given rise to serious problems. These necessitate added concern of PTA's to promote continuing education of parents and youth, in order that both may adjust more effectively to the changing family patterns and build a happier and more useful life.

Therefore, we urge increased emphasis on parent and family life education and suggest that PTA's give priority to programs in this area, including programs to meet the needs of educationally deprived parents.

We further urge increased cooperation with other agencies that have the same concern.

NATIONAL CONGRESS OF PARENTS AND TEACHERS

FAMILY PLANNING

(Adopted by the 1966 Convention Delegates)

Whereas, The National Congress of Parents and Teachers has concern for maternal and child health, family stability, and responsible parenthood, and

Whereas, The National Congress of Parents and Teachers realizes that public concern over world and national population problems has accelerated more than has public action to solve these problems, and

Whereas, Access to family-planning guidance and services frequently depends upon the economic or geographical circumstances of a family; therefore be it

Resolved, That PTA's support efforts toward assuring equal access to family-planning guidance and services, which should be available to any family seeking these services in accordance with its beliefs and needs.

NATIONAL CONGRESS OF PARENTS AND TEACHERS, RESOLUTION

(Adopted by the 1973 Convention of the National PTA)

MENTAL HEALTH PROGRAMS AND SERVICES

Whereas, The National PTA has long been committed to providing improved mental health programs and services to children and youth, and

Whereas, The National PTA, through convention action in 1969, reaffirmed this commitment, and

Whereas, All children and youth have the right to mental health treatment, therefore be it

Resolved, That the National PTA reaffirm its 1969 resolution on Children's Emotional Health,[1] and be it further

Resolved, That the National PTA and its branches encourage each community to make available mental health programs and services which will meet the needs of all children and youth.

Whereas, The National Congress of Parents and Teachers is deeply concerned about the increasing number of children suffering from serious mental and emotional disorders; and

Whereas, It is engaged in an expanded program of mental health through the project on Children's Emotional Health in cooperation with the National Institute of Mental Health; and

Whereas, It recognizes that sound mental health is essential to constructive family life and personal happiness and to the acceptance of civic responsibility; and

Whereas, It realizes that mentally healthy home, school, and community environments are essential to the development of proper attitudes towards oneself and others; therefore be it

[1] Children's emotional health.

70-980—76——3

Resolved, That the National Congress of Parents and Teachers strongly endorses efforts to:

1. Establish comprehensive community mental health facilities to provide preventive and treatment services to children and adults.
2. Improve teacher and administrator understanding of child growth and development to insure the provision of an emotional climate in the school conducive to good mental health.
3. Promote educational programs for parents to improve the atmosphere of the home.
4. Provide special preventive services in the school to detect impending difficulties early.
5. Urge that teacher training institutions incorporate in their programs courses designed to give greater emphasis to children's emotional health.
6. Improve community conditions adversely affecting children's emotional health.

NATIONAL CONGRESS OF PARENTS AND TEACHERS, STATEMENT CONCERNING THE SALE OF CARBONATED BEVERAGES, CANDY, AND OTHER CONFECTIONS IN SCHOOLS OPERATING LUNCH PROGRAMS

(As Originally Adopted by the Executive Committee July 1951 and Amended by the Board of Managers March 1963)

The National Congress of Parents and Teachers, concerned with the health of children, has recognized the need for a sound program of nutrition education in the schools.

The sale of carbonated beverages, candy, and other confections in schools may interfere with effective nutrition education. Many children who spend lunch money for less nutritious foods then are deprived of a valuable learning experience. In this connection we call attention to a similar statement made by the Council on Foods and Nutrition of the American Medical Association.

We recognize that the sale of these items in schools is an *administrative problem* and that the responsibility of the parent-teacher association is *interpreting to parents the* dangers involved in substituting these items for milk and other more nutritious foods in the child's diet, so that parents will give administrators the backing needed to remedy this situation.

We have confidence that school administrators in any community, when they have the complete cooperation of parents, can make any change in practice found necessary for the welfare of our children.

NATIONAL CONGRESS OF PARENTS AND TEACHERS, RESOLUTION

(Adopted by the 1969 Convention of the National Congress of Parents and Teachers)

SCHOOL LUNCH PROGRAM

Whereas, Recent studies have confirmed that undernutrition and underachievment are closely related; that children who are well fed are more receptive to learning than children who are hungry; and

Whereas, Despite the widespread recognition of the value of the National School Lunch Progrm (which includes the special school breakfast program), it is not reaching large numbers of children who need good nutrition; and

Whereas, In most junior and senior high schools it is taken for granted that cafeterias contribute to the convenience and efficiency of the students while in many elementary schools it has been assumed that a walk home for lunch is better for young children, a viewpoint which does not always consider the needs of many of those children for whom home is too far away, clothing is not warm enough, and more importantly, there may be nobody at home to prepare lunch, or no adequate food available; and

Whereas, A people who have generously extended a helping hand to ease hunger around the world can no longer ignore the hunger of our own children by whatever source it is generated, whether ignorance, indifference, or poverty; therefore be it

Resolved, That local PTA's study the school lunch needs in their own communities so that existing school food service programs be strengthened or that new ones be established; that such programs make lunches available to *all*

children at a minimum cost with special provision made for free and reduced-price lunches for those who cannot afford to pay; and that such programs be a part of the education program of the school, teaching good nutrition and good eating habits; and be it further

Resolved, That PTA's provide parents with information about the school lunch program and their children's right to be included in it; and be it further

Resolved, That PTA's urge educators, school board members, and the total community to support and use the National School Lunch Program.

NATIONAL CONGRESS OF PARENTS AND TEACHERS

EDUCATION ON THE ABUSE OF ALCOHOL AND OTHER DRUGS

(Resolution Adopted by the 1968 Convention Delegates)

Whereas, There is universal recognition that we live in a drug-oriented society; and

Whereas, Though many drugs are used for the benefit of mankind, there are available certain drugs which have a detrimental effect on the user unless taken under medical supervision; and

Whereas, Some persons (including young people) medicate themselves, often with injurious effects, and seek to obtain drugs through illegal channels; and

Whereas, Medical opinion holds that some of these drugs may have little medical value but may still be dangerous to health when used without medical supervision;

Whereas, the National Congress of Parents and Teachers does not accept the argument that the social acceptability of alcohol justifies the social acceptability of certain other drugs, such as marijuana; therefore be it

Resolved, That the National Congress of Parents and Teachers is opposed to encouraging social acceptance of the use of such drugs and opposed to legalizing their availability; and be it further

Resolved, That the National Congress of Parents and Teachers, its state boards, districts, councils, and local units stress that education on the abuse of alcohol and other drugs be emphasized among other health problems in comprehensive school and public health education programs.

NATIONAL CONGRESS OF PARENTS AND TEACHERS

(Resolution Adopted by the 1964 Convention Delegates)

Whereas, The U.S. surgeon-General's report has defined the health hazards of smoking; and

Whereas, Young people are specially susceptible to group pressure regarding smoking; therefore be it

Resolved, That the National Congress of Parents and Teachers make every possible effort to cooperate in the education of children and youth regarding the hazards of smoking.

Mr. MEEDS. I was particularly struck with the fact that you have undertaken a survey across the Nation on the question of school health education. The results of that indicate that it is spotty, inadequate. As I recall from your testimony, two of the 500 replies indicated that they felt school health education was adequate in their schools.

Ms. HERNDON. I believe it is four, but it is still minimal.

Mr. MEEDS. Despite that fact, Ms. Herndon, we have an indication that the Administration has indicated in a letter from the Secretary that many of the subject areas of this bill are already being taught, and being supported by Federal funds in other areas.

I don't know what they base their judgment on. I am sure that they don't have a survey like you do Do you believe, despite your survey, that the Administration's feeling of adequacy is correct?

Ms. HERNDON. I cannot believe, Mr. Chairman, that we do have adequaet comprehensive health education in any school system, the entire school system, according to our information. They may have

an adequate program in one school within a school district, but other schools, even within that same district might not have. So, I cannot believe that we have adequate comprehensive health education in the schools.

Mr. MEEDS. Thank you very much.

The gentleman from Iowa, Mr. Blouin.

Mr. BLOUIN. No questions, Mr. Chairman. Thank you.

Mr. MEEDS. The gentleman from Illinois, Mr. Hall.

Mr. HALL. Nothing.

Mr. CROSS. Mr. Chairman, I would like to ask for permission to enter into the record a list of existing legislative authorizations which correspond to some of the activities under this bill. I also have some questions that we would like to send to you, and ask that the answers be submitted for the official hearing.

Mr. MEEDS. Without objection, the list that you have will be inserted in the record at this point, and your written questions, and answers thereto, will follow the written information here. Also, at this point I would like to have inserted in the record a letter written by the Secretary of HEW, Casper Weinberger, commentary on the legislation.

[Subcommittee inserts follow:]

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 18, 1975.

MS. LILLY E. HERNDON,
President, National Congress of Parents and Teachers,
Washington, D.C.

DEAR MS. HERNDON: During the hearing on H.R. 2600, the Comprehensive School Health Education Act, on March 12, Congressman Meeds, who chaired the hearing granted permission for a number of questions to be asked by mail and for your answers to be included in the official transcript of the hearing.

I am enclosing a list of the questions to which I would like your response. When your responses are complete, please forward a copy of your response to both Chairman Perkins and to myself.

With kind regards, I remain.

Sincerely yours,

ALBERT H. QUIE,
Member of Congress.

Enclosure.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 18, 1975.

MR. LEN TRITSCH,
Health Education Specialist,
Oregon State Department of Education,
Salem, Oreg.

DEAR MR. TRITSCH: During the hearing on H.R. 2600, the Comprehensive School Health Education Act, on March 12, Congressman Meeds, who chaired the hearing granted permission for a number of questions to be asked by mail and for your answers to be included in the official transcript of the hearing.

I am enclosing a list of the questions to which I would like your response. When your responses are complete, please forward a copy of your response to both Chairman Perkins and to myself.

With kind regards, I remain

Sincerely yours,

ALBERT H. QUIE,
Member of Congress.

Enclosure.

CONGRESS OF THE UNITED STATES,
HOUSE OF REPRESENTATIVES,
Washington, D.C., March 18, 1975.

DR. EVALYN GENDEL,
Director, Division of Maternal and Child Health,
Kansas State Health Department,
Topeka, Kans.

DEAR DR. GENDEL: During the hearing on H.R. 2600, the Comprehensive School Health Education Act, on March 12, Congressman Meeds, who chaired the hearing granted permission for a number of questions to be asked by mail and for your answers to be included in the official transcript of the hearing.

I am enclosing a list of the questions to which I would like your response. When your responses are complete, please forward a copy of your response to both Chairman Perkins and to myself.

With kind regards, I remain

Sincerely yours,

ALBERT H. QUIE,
Member of Congress.

Enclosure.

QUESTIONS ON THE COMPREHENSIVE SCHOOL HEALTH EDUCATION ACT

1. Have you examined the Special Projects Act, section 402 of P.L. 93-380, as a possible area for funding? Would the purposes of the Special Projects Act be consistent with what you believe should be a Federal role in health education?

2. It is clear that the Administration is against new categorical programs. How successful can a new categorical program be in terms of implementation under the direction of an Administration that is opposed to it?

3. Why do you believe that health education should be a Federal priority rather than a decision left to each individual state?

4. Do you believe that health education should have a higher priority in the expenditure of Federal funds than, for example, funds for the handicapped or the educationally disadvantaged?

5. Since the Comprehensive School Health Education Act overlaps with a number of other programs already in existence, would you support the termination of those programs so as to provide preferential funding for this bill?

6. Health education is an area that spans two very important areas of public concern, the provision of health services and public schools. Might it not be better to tie the provision of health education to the health professionals rather than the schools?

7. A great deal of attention has been given in recent years to the establishment of HMO's (health maintenance organizations). One of the purposes of an HMO is preventive medicine. It is my understanding that the law establishing the HMO program does require patient education services. In addition, four other health programs require through administrative regulation the provision of patient education programs. Those programs are community health centers, migrant health centers, maternal and child health programs, and the Health Service Corps. Since the concept of comprehensive care through HMO's is flourishing in many areas of the country, does it not make a good deal of sense to have health education programs provided through the health delivery structure so that it is more directly related to those who provide the services?

8. Do you think that health education is really best handled in the school, or is it more properly handled in the home, by doctors and dentists, etc?

9. Do we really know how to teach in the classroom such delicate subjects as human development, mental health, and substance control? Is it not more likely that young people would react more positively to health education if it were taught in the context of the health care system rather than in the context of the schools?

10. Do you have evidence on the effectiveness of health education programs? Do you find that students really pay attention to them, or are they just another requirement that they must sit through?

11. You propose a special curriculum in health education. There are those who would argue that health education should be spread throughout the curriculum to make it more helpful and more meaningful. How do you feel about that concept?

12. Your statement points out that certain areas, such as drug abuse, get priority attention. Would it not really be almost impossible to design a curriculum that would not be affected by the problems of most immediate concern to the community?

13. Your statement indicates that many states do not certify health educators. Do you mean to imply by this that there should be Federal certification?

A Selected Listing of Existing Legislative Authorizations Under Which Health Education Programs Might Receive Federal Assistance

1. Innovation and Support Grants, Part C of Title IV, Elementary and Secondary Education Act (as amended by P.L. 93-380). The Nutrition and Health program under Section 808 of ESEA (see below) is among the programs to be consolidated into Title IV, Part C Grants. In Section 431(a)(2) of such Part C, nutrition and health education programs are specifically mentioned as being among the activities authorized under the Innovation and Support Grant Program.

2. The Alcohol and Drug Abuse Education Act (P.L. 91-527, as amended) would authorize Federal aid to activities in this particular area of health-related education.

3. The Environmental Education Act (P.L. 91-516, as amended) might authorize projects in environmental health, although health education is not specifically mentioned in this legislation.

4. The Nutrition and Health Education Program, Section 808 of ESEA, would, of course, authorize aid for health education program. This legislative authorization will, however, expire on June 30, 1975, and be absorbed into the Innovation and Support consolidation grant program (see above). During fiscal year 1976, only 50% of the funds appropriated for Innovation and Support will be allocated as consolidated grants, with the ramaining 50% to be distributed under the previously existing categorical programs. Under this provision, $950,000 would be specifically earmarked—for Nutrition and Health education in fiscal year 1976. In fiscal year 1977, all funds appropriated for Innovation and Support will be allocated in the form of consolidated grants.

5. Although health education is not specified in the authorizing legislation, health education and services are among the activities funded under Title I, ESEA—education for the disadvantaged. According to sources in the Division of Compensatory Education at the U.S. Office of Education, approximately 2% of Title I, Part A Grants to Local Education Agencies are currently devoted to health education and services for disadvantaged children.

6. Fellowships for the education of health education teachers might be funded under the broad provisions of the Education Professions Development Act (Title V of the Higher Education Act of 1965, as amended). This especially true of Part C—Fellowships for Teachers and Related Educational Personnel—and Part D—Improving Training Opportunities for Personnel Serving in Programs of Education other than Higher Education—of the ERDA.

7. For the Head Start Program, nutrition and health services and education are among the specified activities which are authorized to be supported (Section 511, P.L. 93-644). There exists no comprehensive estimate of the proportion of Head Start appropriations which are allocated to this purpose.

8. Nutrition and health services and education are also among the activities supported under the Follow Through program, most recently authorized by P.L. 93-644. Such services and education are not, however, specified in the legislation, nor does there exist a comprehensive estimate of the amount of Follow Through funds used for them.

9. The Snyder Act of 1921—Public Law 85, 67th Congress—authorizes the appropriation of funds for a broad but unspecified array of programs and services to Indians. Though not specifically authorized, health education programs might be assisted under this authorization. The Johnson-O'Malley Act—Public Law 167, 73rd Congress—is a similarly broad legislative authorization, although it authorizes aid only for education programs. It also might authorize aid to health education programs for Indian children.

10. Section 810 of the Elementary and Secondary Education Act of 1965—Improvement of Educational Opportunities for Indian Children—authorizes activities to meet the special educational needs of Indian children. Among those specifically authorized are "special health and nutrition services, and other related activities (Section 810(b)(3)).

11. Section 6(a)(3) of *both* the National School Lunch Act and the Child Nutrition Act, as amended by P.L. 92-433, authorizes the utilization of up to 1% of the amounts appropriated under these Acts for nutritional education and training of "workers, cooperators, and participants" (students) in school nutrition programs.

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE,
Washington, D.C., March 14, 1975.

Hon. CARL D. PERKINS,
Chairman, Committee on Education and Labor,
House of Representatives,
Washington, D.C.

DEAR MR. CHAIRMAN: There is pending before your Committee H.R. 2599, a bill "To authorize the Commissioner of Education to make grants for teacher training, pilot and demonstration projects, and comprehensive school programs, with respect to health education and health problems". Health education and health problems would include dental health, disease control, environmental health, mental health, family life and human development, human ecology, nutrition, physical health, safety and accident prevention, smoking and health, consumer health, venereal disease, and substance abuse.

Specifically, the bill provides for the following Federal assistance:

I. *Teacher Training:* Authorizes the Commissioner to make project grants to State education agencies and institutions of higher education to develop and conduct programs to train elementary and secondary teachers with respect to health and health problems. Grants must be distributed in a manner which is equitable and seeks to achieve a reasonable geographical distribution. The criteria used by the Commissioner in determining the distribution of funds must be submitted to the designated authorizing committees of Congress 30 days prior to distributing funds. The following authorizations are included: fiscal year 1976, $10 million; fiscal year 1977, $12.5 million; and fiscal year 1978, $15 million.

II. *Pilot and Demonstration Projects:* Authorizes the Commissioner to make grants to State and local educational agencies, institutions of higher education, and other public and private nonprofit education or research institutions to support pilot and demonstration projects in elementary and secondary schools related to health education and health problems.

Grants may be used for: (a) Developments of curriculums and evaluation of existing exemplary materials; (b) Projects to demonstrate, test, and evaluate the effectiveness of curriculum relating to health education and health problems and to provide for its dissemination; and (c) Projects providing preservice and inservice training for teachers and other education personnel with respect to health education and health problems.

The following authorizations for this part are included: fiscal year 1976, $15 million; fiscal year 1977, $17.5 million; and fiscal year 1978, $20 million.

III. *Comprehensive Health Education Programs:* Authorizes the Commissioner to make formula grants to State educational agencies to develop comprehensive programs in elementary and secondary schools with respect to health education and health problems and to assist local educational agencies in implementing these programs.

The Commissioner may reserve up to 3 percent of the funds for outlying territories. Of the remainder, forty percent of the funds would be distributed equally among the States and 60 percent of the funds would be distributed on the basis of the ratio of public school children in a State to the number in all States. Funds may be reallocated.

There are also provisions for services to nonpublic school children.

The Department strongly opposes enactment of this legislation.

First, the Department favors the consolidation of innovation and support programs under one authority when feasible. Thus, we supported Title IV of the 1974 Education Amendments which brings together several such programs, including authority to fund health and nutrition programs under Part C. We feel this Part C authority is sufficient to fund the major activities addressed by H.R. 2599 and would be a preferable vehicle for Federal support in this area.

Under Part C, there will be, starting in fiscal year 1976, authority to support demonstration projects by local educational agencies or private educa-

tional institutions designed to improve health and nutrition services in elementary and secondary schools serving concentrations of low-income children. This support could include payment for supplemental mental health, health, nutritional, and food services.

Until that authority goes into effect, we are supporting health and nutrition activities under Section 808 of the Elementary and Secondary Education Act. In fiscal year 1975, we will be supporting, with $900,000, three new grants in this area.

For fiscal year 1976, when the Part C consolidation is only partially implemented, $950,000 is earmarked for health and nutrition activities. Local educational agencies will also be able to apply for funding of health education activities, along with other priorities, under the $86.5 million consolidated portion of Part C. These funds were appropriated by Congress in P.L. 93-554.

For fiscal year 1977, the Administration is requesting $173 million for the Part C consolidation, which will be fully implemented by that time.

We believe that all of the needed, Federally supported programmatic activities in health education can be funded under this broad consolidated authority according to State-determined priorities; and that a new categorical program is not warranted at this time.

The teacher education protions of H.R. 2599 also duplicate existing authority unnecessarily. In-service training of teachers already is authorized under the Education Professions Development Act, the Special Projects Act and the Part C consolidation authority. Part C explicitly authorizes support for training activities for professionals and other school personnel involved in delivering health and nutrition services. Moreover, we are not aware of any lack of adequate curricula or shortages of capable teachers to advise children of the importance of good health practices and good nutrition.

Second, H.R. 2599 provides excessive funding for program levels for which the need has not been demonstrated. Authorization levels would rise to $85 million by fiscal year 1978, compared with the authorization of $26 million for the Section 808 school nutrition and health services program.

Third, H.R. 2599 would not target resources to areas of greatest need. While Part C, Title IV of P.L. 93-380, focuses assistance on low-income children, H.R. 2599 requires grants for comprehensive health programs to be apportioned by a formula which serves all children regardless of need or the ability of school districts to finance the services in question.

Finally, you should know we are implementing recommendations by the Advisory Council to the President on Comprehensive Health Educaton and to that end have recently established a new Bureau of Health Education in the Center for Disease Control which will look at the total efforts of the Department of Health, Education, and Welfare in health education. This Bureau will ensure a coordinated and focused approach to the type of problems H.R. 2599 seeks to address.

For these reasons, we urge that H.R. 2599 not be favorably considered.

We are advised by the Office of Management and Budget that there is no objection to the presentation of this report and that enactment of the bill would not be consistent with the Administration's objectives.

Sincerely,

CASPAR W. WEINBERGER,
Secretary.

Mr. MEEDS. Again, Ms. Herndon, thank you very much, and also Grace Baisinger, who is accompanying you. We think she is a very, very fine help to us on the subcommittee, not only working the legislation through, but working the legislation up.

Ms. HERNDON. Thank you, Mr. Chairman.

Mr. MEEDS. Our next witness is Len Tritsch, who is the president of the American Association for Health Advancement.

Len, again let me welcome you to the committee, and the organization to which you belong. The support which you have given, and those who work with the organization have given this legislation, is almost beyond description. We appreciate your presence.

STATEMENT OF MR. LEN TRITSCH, PRESIDENT, AMERICAN ASSOCIATION FOR HEALTH ADVANCEMENT

Mr. TRITSCH. Mr. Chairman, and members of the committee, I am Len Tritsch, the president of the Association for Health Advancement, and specialist in health education for the Oregon State Department of Education.

With me this morning is John Cooper, our national executive secretary for our association. I will not read the written testimony, but I would ask that you follow along, as I summarize. You have the written testimony before you.

Mr. MEEDS. Without objection, your full written statement will be inserted in the record.

[Prepared statement of Len Tritsch follows:]

PREPARED STATEMENT OF LEN TRITSCH, PRESIDENT, ASSOCIATION FOR THE ADVANCEMENT OF HEALTH EDUCATION

Mr. Chairman and Members of the Sub-Committee, I am Len Tritsch, president of the Association for the Advancement of Health Education and specialist in Health Education for the Oregon State Department of Education. I want to thank you for the opportunity to testify in support of the Comprehensive School Education Act. As national leads and members of the House Sub-Committee on Elementary, Secondary and Vocational Education, you are aware of and knowledgeable about the educational and health related problems of our country. Therefore, this testimony will be addressed to a rationale for the need for Comprehensive School Health Education Legislation and to problems facing the implementation of school health education programs.

RATIONALE FOR THE NEED OF COMPREHENSIVE SCHOOL HEALTH EDUCATION LEGISLATION

If the goals of education are to promote development for more humane beings in a society beleaguered by dehumanization, then education about health is necessary to preserve individual self-concept and the concern for survival. The nature of health related problems that afflict us as individuals and as a state and nation have become staggering in number and scope. Science and technology have lagged in helping people learn to cope with the significant health problems to which rapid technological development has strongly contributed. Thus the high incidence today of such problems as cancer, heart disease, accidents, mental illness, venereal disease, drug abuse, malnutrition, environmental pollutions, and emphysema, to name only a few, is a real cause for concern in our state and nation

Health education can provide the individual with opportunities to learn to recognize and accept the major responsibility for his own health and partial responsibility for the health of others. Health education can further assist each individual to understand his behavior through the development and use of a valuing system. Helping people acquire the tools for adapting to and coping with the environment in which they find themselves is a justifiable reason for developing and implementing Comprehensive School Health Education programs.

PROBLEMS WHICH PREVENT THE IMPLEMENTATION OF COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS

Generally U.S. Citizens do not value individual health until it is lost.

Comment: Even though the general public is aware of the seriousness of cardivascular problems they do not become concerned about their health habits (eating, smoking, exercise) until after they have suffered from a heart attack, hardening of the arteries, or other related threats to their life.

National, state and local leaders/administrators have not given financial support to the development of comprehensive school health education programs.

Comment: Monies have been and are being provided for crises approaches to health problems such as the abuse of alcohol and other drugs. Little or no money is provided to help develop a program that helps people understand how an action which aids or is destructive to health will affect one's total health.

Health education programs are non-existent; only classes and courses are offered.

Comment: There are many curriculum guides which have been developed for health education programs K–12. However, I have not been able to identify one school district which has health being taught sequentially at every grade level. Many outstanding classes or courses are taught but most often those are at the high school level, which is generally too late to affect attitudes.

Dissemination of Information is confused with health education.

Comment: The viewing of a film or reading of a brochure/book which provides much factual information is/was most often considered to be health education. This is part of health education, but experience which help individuals develop coping skills and attitudes which will contribute to healthy productive life are other components of health education.

Inconsistent health behavior in Health Education/Services, that is, a gap between knowledge and behavior.

Comment: Modeling is a very powerful teaching method; therefore, persons involved in Health Education/Services who do not exhibit behaviors consistent with those they encourage others to practice are looked at as hypocrites.

Health Education is more often illness education which is concerned with treatment rather than prevention.

Comment: Typically in a unit on mental health, the content would deal with topics such as schizophrenia, its symptoms and treatment; rather than how an individual can improve and maintain good mental health.

Often, individuals teaching health education are not aware of their true feeling about health education.

Comment: Persons teaching health education may verbalize a health concept, e.g. importance of proper diet, but when confronted with the inconsistency of their behavior, may find pleasure to be more important than health.

Inadequate preparation of health educators/those teaching health education.

Comment: Many states do not require certification of health educators or those teaching health education, especially at the elementary school level. Many of those who do require certification are satisfied with a minimum of nine quarter hours which could be satisfied with courses in first aid, anatomy, and community health.

Fragmented efforts to improve health education by governmental agencies, professional individuals and organizations.

Comment: Federal and state agencies have made monies available for crisis situations, e.g. drugs-alcohol. As a result everyone wants to get into the act and each has gone his/her own way resulting in attempts to establish curricula in drug education, alcohol education, venereal disease education and so on as a part of school programs.

ACTION WHICH WOULD FACILITATE IMPLEMENTATION OF COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAMS

Passing and funding of the Comprehensive School Health Education Act which would:

Encourage states to appropriate funds for the purpose of developing such programs.

Comment: After the U.S. Government takes a leadership role in identifying priorities, states seem to follow. As an example, in Oregon we have been able to get legislation introduced which will complement the Comprehensive School Health Education Act provided they are both enacted and funded.

Provide monies to conduct activities for educating school administrators as to the nature of health education.

Comment: School administrators decide which programs will be developed and implemented because they control the monies. Until administrators are

educated to the fact that health education is not memorizing bones and muscles, meaningful health education programs will be non-existent.

Provide monies to conduct education activities for those presently teaching health education or will have the responsibility, who have little or no training in the area of health education.

Comment: The key to successful health education is the competent classroom teacher. In Oregon studies indicate that 1 in 10 secondary teachers of health education are properly prepared, while nearly 100% of the elementary teachers have little or no preparation to teach health education.

Make it possible for students to have an opportunity to benefit from a comprehensive school health education.

Comment: If we are to influence the health attitudes and behaviors of individuals it is imperative that formal health education be started in the first year of school. There must be reinforcement each year through a meaningful, sequential health education program.

CONCLUSION

Valuing life and health can more readily occur if national effort, commitment and financial support are given to a basic continuum of learning which encourages individuals to become all that they can become.

The problems and costs of caring for individuals who are ill, become greater each day. The need for research, personnel, and facilities will continue and will multiply, until at some point the full influence of education is brought to bear.

Thank you for the opportunity to present testimony in support of the Comprehensive School Health Education Act. I urge the Sub-Committee to take prompt action to approve this significant education legislation.

Mr. TRITSCH. The reason I will not read my testimony is that there is much duplication in my testimony of what has already been mentioned. Therefore, I choose not to take the time.

I first would like to address myself to problems which prevent the implementation of comprehensive school health education, which is found on page two of the written testimony.

Probably the number one reason for not having comprehensive health education is the attitude of the U.S. public toward health in general. Generally speaking, the U.S. citizens do not value individual health until it is lost.

As an example, people who suffer from serious cardiovascular problems are generally not concerned about their health habits, such as eating, smoking, etc., until after they have suffered from a heart attack, hardening of the arteries, or some other type of health problem.

Secondly, the second problem is that the national and state, and local leaders or administrators have not given financial support to the development of comprehensive school health education.

I guess I would jump down to the local level, where the action is, unless we are going to have administrators who are going to provide the bucks, no matter how dedicated the teacher is, or how interested the people are, you are just not going to have a comprehensive health education program. Thus, the need for the passage of this important bill, to provide monies that would make it possible for administrators to provide appropriate allocations.

Health education programs are non-existent. Only classes and courses exist. In reading the literature and corresponding with my counter-part in the other 50 states, we have a lot of good classes, but we do not have programs.

When I identify a comprehensive program, I am talking about a K through 12 program, in which we have health education offered

at every grade, and to every elementary student K through 12, or at least K through 8.

In the State of Oregon, which is supposed to be one of the leaders in the field of health education, we have done research and we do not find programs. We find classes and courses.

A third problem is the misunderstanding, or the confusion of dissemination of information versus health education. Many of our so-called health education classes are classes where they disseminate information. There are films, books, and brochures that are used, and this is the end of education.

I say that in order for this to become meaningful time, a process must be provided where the student has a chance to internalize the information, and apply it to himself. Unless this process and time is provided, he will continue to get most of his information from television, as was mentioned before.

Another problem is the inconsistent behavior in health education and services. It is a gap between knowledge and behavior. Modeling by adults is one of the most powerful tools that we have.

We see students today talking about hyprocrisy, or perceive hypocrisy as they see it. The people who are advocating health education do not live by what they are advocating. The health educator who smokes, the 200 pound nutritionist, etc.

The students, as I said, look at this as being hyprocritical, and the people who have the knowledge and apply this knowledge, it is going to be pretty tough to convince them that they should apply this knowledge to their own lives.

Health education is more often illness education, which is more concerned with treatment than prevention. Upon reviewing many, many curricula, I would just take one example. The unit in mental health is not a unit in mental health. It is a unit in mental illness. It is much concerned about paranoia, schizophrenia, and this type of thing, and what happens to you, where you go for treatment, etc., rather than emphasizing the way to maintain or improve good mental health.

The idea that mental health is not static, it is not continuum, and not always are you going to be at one end, or the other. How do you maintain an even balance.

One of the most important problems facing us: There are often people teaching health education who are not aware of their true feelings about health education.

I don't want to confuse the person teaching health education, and the health educator, because there is a very big difference between the two.

Very often the teachers who are teaching health education—I guess I have mentioned this before—they sort of advocate, or think that they believe that health is important. However, when they start to internalize and take a look at their own health habits, they find a certain distaste for this. I would use venereal disease education as an example.

Last year, when we were doing venereal disease education, one of the questions put to the teacher was: "How would you feel about a student who had venereal disease in your class? Would this change your attitude toward that student?"

The common response was that it would not. But when we got into some smaller groups, and got down to gut-level feeling, there surfaced the idea, yes, I would feel differently about that particular person.

Another problem facing the implementation of comprehensive health education is the matter of appropriation of health educators, and those teaching health education. Very few states require certification for people who are teaching health education. Many of those who do require certification are satisfied with a minimum of three hours of health education. There are a few more that have moved up, and we now have 24 states that have greater certification. This is certainly one of our big problems.

Fragmented efforts to improve health education by governmental agencies, professional individuals and organization; we have had a lot of money that has been poured into alcohol education, drug education, nutrition education, but we have never tried to have a concerted effort.

This bill will give us the opportunity to do this. Each one has been identifying their own turf, going their own way, rather than having attempted to have a comprehensive and cooperative effort.

Those are a few of the problems that I see facing the implementation of health education. So, I am saying that the passage of this bill would allow us to do a few things. One would be to encourage states to appropriate funds for the purpose of developing such programs.

In the State of Oregon, as a result of this pending legislation, we have been able to get introduced into our own legislative body, a similar bill with a lesser amount of money that would be used specifically for in-service for every elementary teacher in the State of Oregon.

This is not to say that every elementary teacher should teach health education, but they should be alerted to the need for health education.

The most critical thing, I think, this bill can do is to provide monies to conduct activities for educating school admnistrators as to the nature of school health educaton. We can have all the prepared health educators we want. We can develop all the curriculum we want, but until the administrators of schools are sold on the need for health education, and they cannot be sold until they over the old, antiquated idea that health education is memorizing bones and muscles. This is not health education today.

So, this is a very important thing.

The last thing that I would mention would be the necessity of developing a meaningful curriculum. We have a lot of good paper curricula for K through 12, but a lot of this goes back to presentation of factual information rather than proving process, and developing of skills, so that our young people will be able to cope with the many health problems that face them today.

I thank you for the opportunity of testifying today, and I urge that prompt action be taken to get this legislation passed.

Mr. MEEDS. Thank you very much, Len.

I would like to preface my question with a statement. The witness and the chairman worked very closely together for a number of years

in fashioning the legislation on drug abuse. He is from God's country, out there in the Pacific Northwest, so we have a special affinity.

One part of your statement struck me, Len, particularly where you state that dissemination of information only was not the way to have health education programs. The fact is, as we found out in the drug abuse education, dissemination of information only can be counterproductive, can it not? That is what is largely happening in health education day.

So, if we are going to have a health education program, and I would like to make a distinction between classes and a program, because I believe that thoroughly, if we are going to have comprehensive health education programs, we are going to have to do more than simply disseminating information, are we not?

I could ask a lot of question, but your testimony was excellent. It pointed out many of the important things that we found in the drug abuse education, which is, after all, part of health education, isn't it.

Mr. TRITSCH. Yes, definitely.

Mr. MEEDS. The gentleman from Illinois, Mr. Hall?

Mr. HALL. I have no questions. I enjoyed the presentation.

Mr. MEEDS. The gentleman from Oklahoma, Mr. Risenhoover?

Mr. RISENHOOVER. I have no questions. Thank you very much for coming here.

Mr. MEEDS. Len, thank you very much for your testimony, and your help. It was good to see you both.

We will take one more witness. As you know, we have this morning, a democratic caucus on the Cambodian question, which has preempted our hearings. So, we will finish this morning's testimony with Dr. Evalyn Gendel, Director of the Division of Maternal and Child Health, Kansas State Health Department.

Dr. Gendel, thank you for coming. We are delighted to have you before the committee.

STATEMENT OF EVALYN GENDEL, M.D., DIRECTOR, DIVISION OF MATERNAL AND CHILD HEALTH, KANSAS CITY STATE HEALTH DEPARTMENT

Dr. GENDEL. I am Evalyn Gendel, and along with me is Ms. Davidson from the Public Health School Health Division, who works here in Washington, D.C., and has been a tremendous help.

I am a physician with the division of maternal and child health in the new Department of Health and Environment of the State of Kansas. It is a pleasure to be here.

Mr. Chairman, I come before you today with a number of years of direct experience with health problems relating to children. You do have a copy of our printed testimony, and I will try to abstract some of that, because I know the pressure of time.

Mr. MEEDS. Without objection, your prepared statement will be made a part of the record at this time.

[Prepared statement of Dr. Evalyn Gendel follows:]

PREPARED STATEMENT OF EVALYN GENDEL, M.D., DIRECTOR, DIVISION OF MATERNAL AND CHILD HEALTH, KANSAS CITY STATE HEALTH DEPARTMENT

I am Evalyn Gendel, a physician and Director of the Division of Maternal and Child Health with the Kansas State Department of Health. In addition,

I am a member of the American Public Health Association's Executive Board. Mr. Chairman, I come before you today with a number of years of direct experience with health problems relating to children. In fact, a former colleague of yours Congressman William Roy, and I used to ride the public school circuit together discussing health issues with the students in Topeka and the surrounding areas. It is on the basis of these broad-based health experiences rather than inside expertise in schools or teacher preparation that I share my thoughts with you today.

It is my privilege to represent the American Public Health Association, an organization of 50,000 regular and affiliate members who encompass a broad spectrum of health and health-related disciplines including a substantial number of health educators working in a variety of settings. The American Public Health Association is committed both to the concept that health education should be a continuing process throughout life and, also, to the task of promoting the recognition of the need and potential for health education. In 1974, its 102nd Annual Meeting, the American Public Health Association adopted a position paper on Education for Health in the School Setting, a copy of which is included with this statement for your consideration and with your permission for inclusion in the Record.

In view of the high priority that my organization attaches to health education, I would like to express our appreciation to the sponsors of this legislation for your great efforts to overcome shocking inadequacies of present programs. Since you are already aware of them, I will refrain from restating the findings of the President's Committee on Health Education regarding the nation's low investment in this field and the weaknesses of present programs.

I would like to devote a brief amount of my time this morning to outlining some of the bases for our specific interest in school health education.

First, if we reach young people in the school years, they can acquire solid foundations, not only to prevent and minimize health problems and enhance their health for a full lifetime, but to safeguard the health of their future families and of the communities in which they live. As a setting whose primary purpose is education for a period of twelve or more years in the life of each individual, schools provide opportunities for sustained and systematic health education unequaled elsewhere. Then, too, no other community setting even approximates the magnitude of the nearly 17,000 school districts with their nationwide enrollment in 1973-74 of 45.5 million and some 2.1 million teachers.

Second, APHA is concerned about the traditional crisis approach to health care. Health education is caught up in a "revolving critical issue syndrome," moving from one fragmented special interest to the next and the next and back again—failing all the while to develop a comprehensive and coordinated program with substance and meaning for young people.

Third, we believe that today's health problems do not lend themselves to yesterday's solutions. Such problems as accident prevention, substance abuse, nutrition and weight control, and family breakdown are not resolved by the public health sanitation measures and immunization campaigns that have achieved such success in the past, important as these efforts continue to be. Many of today's health problems are matters of lifestyle and behavior that are governed in large measures by personal choice. Such problems arise for the most part *not* from medical failures, but from educational failures.

Fourth, we are also concerned, as I know you are, about the soaring cost of medical care for treatment, rehabilitation, recuperation and restoration. We see a redirection of the nation's health goals toward a primary preventive—and constructive—approach to health through education as a way to help control these costs and get more value for our investment in health.

Lastly, in addition to personal health problems, we face major public health problems—concerning the environment and the provision of medical care for the whole population. A health education citizenry is sorely needed if our democratic society is to address these issues in an intelligent, rational manner.

In order to meet these needs, the American Public Health Association supports: "A national commitment to a comprehensive, sequential program of health education for all students in the nation's schools, kindergarten through twelfth grade. . . . to assure for health education (1) time in the curriculum commensurate with our subject areas, (2) professionally qualified teachers and supervisors of health education, (3) innovative instructional materials and appropriate teaching facilities, (4) increased financial support at the local,

state, and national levels to upgrade the quantity and quality of health education and (5) a teaching/learning environment in which opportunities for safe and optimal living exist, and one in which a well-organized and complete health service is functioning."

I would like now to comment on some specific features of the "Comprehensive School Health Education Act" itself:

The scope of health education, as defined in the Bill, provides for the comprehensive health education programs from the elementary grades through secondary school that we believe are needed. The topics identified from dental health through venereal disease provide a framework for balanced, coordinated programs that can avoid the pitfalls of current crises and fads.

In specifying the purposes of grants, this bill goes to the heart of the matter in providing for teacher training, both pre-service and in-service. We are acutely aware, on the one hand, of teachers who feel ill-prepared and insecure and therefore neglect to teach health and, on the other hand, of teachers who perpetuate health myths or impose their own mores in the often-mistaken belief that their eating patterns or their particular standards of cleanliness are essential to health.

Further, the provisions for technical assistance both at the Federal level and through state education agencies can also go far toward effective program implementation.

The success of local programs can often be enhanced through such efforts, particularly during their formative stages. The improvement of administrative capacity, of curriculum development, or of linkages with other health resources within the community, to name a few, can be achieved through such assistance.

Also, the proposed support specifically for curriculum development and for preparation, demonstration, evaluation, and dissemination of materials will multiply the effect of this bill far beyond the immediate grant recipients. By encouraging curriculum development, this bill should make it possible to strengthen some aspects of school-centered health education about which the American Public Health Association is especially concerned. These include such areas as the health of the urban, poor, and minority populations, family life and human development, and consumer health—areas which have traditionally been neglected even in many schools with relatively advanced programs.

An indication of the current inadequacy of health education relevant to urban, poor, and minority populations may be found in a recent analysis of minority-related content in 20 college health texts, the very books from which many teachers acquire their knowledge of health.

The author of the study found "massive neglect" beyond the "extremely poor quality" of what little content there is on specific minority health problems like sickle cell anemia and life expectancy.

The need to strengthen and expand education in family life and human development for the total population is evidenced by the growing pregnancy rate among teenagers and the high divorce rate, especially for those couples who marry at young ages. It is extremely important that the physical aspects of human growth and development be integrated with the psychological aspects—a task which has often been left to students alone. Preparation for responsible parenthood is increasingly needed. The physical age of readiness for sexual activity has declined but readiness for social responsibility remains high. Frequently, young people become parents during this gap between physical readiness and social-emotional preparation. The young person is even less equipped psychologically to cope with the responsibilities of parenthood than with his own personal growth.

Ignorance of sexual physiology will not prevent sexual activity; frequently it will cause unwanted pregnancy. Education for responsible sexual development and responsible parenthood are essential elements of any comprehensive health education program. Such education should engage the best efforts of health professionals and colleagues from related fields—indeed, almost all academic fields from langauge arts to mathematics are relevant. The program should be based on research into needs and knowledge of young people, and should be continuously evaluated. Finally, the curriculum should not only be designed with young people in mind, but with their active participation and continuing involvement. These principles are long-standing with APHA and as early as 1969 they were incorporated into a resolution which is attached for your consideration and, with your permission, for inclusion in the record.

In the larger sense, all of health education develops informed health consumers. In the more specific sense, consumer health refers to the selection and use of health-related products and services—products such as medications and foods, and services such as physical examinations, laboratory procedures, public health resources, and solo or group practice. The far-reaching School Health Education Study of the 1960's showed that consumer health was omitted by a majority school systems in grades Kindergarten through 8 and was among the content areas *least* emphasized in grades 7–12.

Today, with the Patient's Bill of Rights, with rapid changes in health care, and with escalating costs, helping young people to be informed health consumers is all the more important. With the erosion of belief in established advice-giving authorities, individuals become easy prey for predators and need all the help we can give in understanding and assessing choices among health products and services. In addition many health planning and policy questions will necessitate a health-educated citizenry.

In this connection, it is worth noting the growing evidence of the cost-effectiveness, as well as the human benefits, of patient education in medical care settings. Patients who understand and have a sense of involvement in their own health care give better medical histories which result in better diagnoses; they have fewer broken appointments and pay more bills on time; and they have greater compliance with medical regimens such as medication, diet and exercise and follow through with referrals. In the words of the noted health economist Dr. Victor Fuchs, "the greatest potential for improving health is through changes in what people do and do not do to and for themselves." More effective consumer health education during the school years would surely lay the foundation for enhancing such benefits by simplifying and improving the quality of individual interactions with the health care delivery system.

Looking ahead, there is every reason to believe we will soon have some form of National Health Insurance. It is expected that coverage will include preventive services such as health education. Maximum use of existing settings and of organized systems for the delivery of these services will be essential to a national health insurance system in providing such services and in assuring quality, and the schools are sure to play a key role in these future efforts. The Bill you are now considering provides an opportunity to prepare schools and school staff for such new responsibilities in serving the school-age population and possibly community groups as well.

In conclusion, we see this bill as practical in its specific provisions for developing qualified teachers, and realistic in that these steps would be taken on a low budget to try a variety of approaches and determine which are most effective.

On behalf of the American Public Health Association, I would like to express our appreciation for the opportunity to share our thinking with you and commend the sponsors of this bill for their vision and efforts to move us substantially forward on the road to more meaningful health education for the people in our nation's schools.

SCHOOL HEALTH SECTION POSITION PAPER[1] EDUCATION FOR HEALTH IN THE SCHOOL COMMUNITY SETTING ADOPTED BY THE GOVERNING COUNCIL OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, OCTOBER 23, 1974, NEW ORLEANS, LA.

The school is a community in which most individuals spend at least twelve years of their lives, and more if they have the advantages of early childhood programs, college education, and continuing education for adults. The health of our school-age youth will determine to a great extent the quality of life each will have during the growing and developing years and on throughout the life cycle. Their capacity to function as health educated adults will in turn help each to realize the fullest potential for self, family, and the various communities of which each individual be a part.

The American Public Health Association believes that health education should be a continuing process, from conception to death, and that such education must be comprehensive, coordinated, and integrated in *all* community planning for health.

[1] A Position Paper is defined as a major exposition of the Association's viewpoint on broad issues affecting the public's health.

70-980—76——4

The school, as a social structure, provides an education setting in which the total health of the child during the impressionable years is of priority concern. No other community setting even approximates the magnitude of the grades K–12 school educational enterprise, with an enrollment in 1973–74 of 45.5 million in nearly 17,000 school districts comprising more than 115,000 schools with some 2.1 million teachers. This is to say nothing of the administrative, supervisory, and service manpower required to maintain these institutions. Additionally, more than 40 percent of children aged three to five are enrolled in early childhood education programs. Thus it seems that the school should be regarded as a social unit providing a focal point to which health planning for all other community settings should relate.

Schools provide an environment conducive to developing skills and competencies which will help the individual confront and examine a complexity of social and cultural forces, persuasive influences, and ever-expanding options, as these affect health behavior. Today's health problems do not lend themselves to yesterday's solutions. Specificity of cause is multiple rather than singular. The individual must assume increasing responsibility for solutions to major public health problems, and consequently must be educated to do so.

Education for and about health is not synonymous with information. Education is concerned with behavior—a composite of what an individual knows, senses, and values and of what one does and practices. Factual data are but temporary assumptions to be used and cast aside as new information emerges. Health facts unrenewed can become a liability rather than an asset. The health educated citizen is one who possesses resources and abilities that will last throughout a lifetime—such as critical thinking, problem-solving, valuing, self-discipline, and self-direction—and that lead to a sense of responsibility for community and world concerns.

The school curriculum offers an opportunity to view health issues in an integrated context. It is designed to help the learner gain insights about the personal, social, environmental, political, and cultural implications of each issue. Planning for health care delivery, for example, is not simply a matter of providing for manpower, services, and facilities. These things must be considered in concert with housing, employment, transportation, cultural beliefs and values, and the rights and dignity of the persons involved. Nor will nutritional practices be improved substantially by programs based on groupings, labeling, or issuing stamps, because food practices and eating patterns are equally influenced by how, when, where, why, and with whom one eats.

APHA is concerned about the traditional crisis approach to health care. The expense involved in treatment, rehabilitation, recuperation, and restoration to health has sent medical costs soaring. More facilities, more services, and more manpower to staff the facilities and to provide the services appear to be the nation's leading health priorities. The alternative is a redirection of the nation's health goals towards a primary preventive—and constructive—approach to health, through education for every individual.

Because of vested interests, political pressures, mass media sensationalism, and health agency structures with categorical interests, health education programs in schools are compelled to deal with a multitude of separate health issues, with only a few of these given priority at any given time. Too frequently, programs developed to deal with crucial issues are eliminated although the problems remain, because another crisis emerges calling for more new crash programs. A revolving critical issue by syndrome has been the result, with the same problems considered crucial a decade or more ago emerging once again. Focusing on selected categorical issues has potential value if time, energy, personnel, and money are available to sustain the emphasis and expand such efforts into an integrated and viable health education framework. A broad concept of healthful living that has consideration for psychological dimensions, should be the basis for health education.

APHA is encouraged by recent developments in an increasing number of states which attest to recognition of the significance of a comprehensive health education program in grades kindergarten through twelve. Also encouraging are the exemplary programs being established in many school districts, and the expressed intention of the federal government to implement an action plan for "Better Health Through Education."

Therefore: the American Public Health Association supports the concept of a national commitment to a comprehensive, sequential program of health educa-

tion for all students in the nation's schools, kindergarten through the twelfth grade. The Association will exert leadership through its sections and affiliates to assure for health education (1) time in the curriculum commensurate with other subject areas, (2) professionally qualified teachers and supervisors of health education, (3) innovative instructional materials and appropriate teaching facilities, (4) increased financial support at the local, state, and national levels to upgrade the quantity and quality of health education and (5) a teaching/learning environment in which opportunities for safe and optimal living exist, and one in which a well-organized and complete health service is functioning.

SPECIFIC METHODS TO BE USED FOR IMPLEMENTATION

The American Public Health Association will:

Publicize and support the concepts expressed in H.R. 13084 and 13085, and in S. 3074 bills of the 93rd Congress Second Session (Comprehensive School Health Education Act).

Contact state APHA affiliates and recommend their involvement in offering support and endorsement to the State Commissioner of Education in those states which have within recent years passed K–12 Comprehensive Health Education legislation (e.g., New York, Florida, Illinois); and to offer APHA leadership to other states seeking comprehensive health education legislation for schools.

Encourage APHA staff members and officers to incorporate in their public messages a statement calling for K–12 comprehensive health education programs in all schools and use the *American Journal of Public Health* and *The Nation's Health* as media for editorials and for reports of legislation.

Monitor the development and operation of the Bureau of Health Education, CDC, established July 1, 1974, and the proposed Center for Health Education representing the private sector (both recommended by the President's Committee on Health Education), to assure emphasis on the importance of health education in schools and provision of the adequate funding essential for high quality programs.

Examine manpower legislation for the health professions to assure that health education professional preparation programs for positions in schools, colleges, and other community settings are specified as eligible for traineeships and other grants.

Seek grant support explore and clarify the function of health educators in schools and a variety of community settings (e.g., colleges, agencies, organizations, hospitals, industry, HMOs, action projects).

Recommend that each State Department of Education seek budgetary support to add one or more fully qualified health educators to its staff for consultant services to school districts.

Appoint a task force comprised of appropriate APHA sections and representatives and affiliates to guide the Association's efforts on behalf of health education and designate a staff member to coordinate and activities.

A Partial List of National Organizations and Groups in Support of Health Education in Schools (As Reflected in Position Statements, Resolutions Conference Reports, and other Professional Literature).

American Academy of Pediatrics, American Alliance for Health, Physical Education, and Recreation, American Association for the Advancement of Health Education, American Association of School Administrators, American Dental Association, American Medical Association, American Public Health Association, American School Health Association, Chief State School Officers, Department of Health, Education, and Welfare, International Union for Health Education, Joint Committee on Health Problems in Schools of the National Education Association and the American Medical Association, National Association of Elementary School Principals, National Association of Secondary School Principals, National Congress of Parents and Teachers, National Health Council, National School Board Association, School Health Education Study (1961–1972), and SEICUS (Sex Education and Information Council of the United States).

Examples of Reports from: National Commission on Community Health Services, 1966, President's Commission on National Goals, 1960, President's Committee on Health Education, 1973, Quality of Life Conferences (AMA), 1972, 1973, Schools for the Sixties (NEA Project on Instruction), Schools for the Seventies (NEA Project on Intsruction), and White House Conference on Children and Youth, 1970.

APHA RESOLUTION—1967

HELPING YOUTH ACHIEVE HEALTHY SEXUAL ADJUSTMENT

Sexual attitudes and practices are related, on the positive side, to healthy family living and, negatively, to the problems of venereal disease, illegitimate pregnancy, and emotional disturbance connected with sex functions and drives. Concern over such matters is becoming increasingly manifest among the problems faced by American youth today.

The American Public Health Association encourages the development of programs that aim to help parents and community groups to promote healthy sex attitudes and to meet their respective responsibilities toward the problem more fully. Elementary and secondary schools should provide organized programs that give students opportunity for guided discussion appropriate to their stage of readiness and maturity so that better knowledge associated with parental counseling may help them develop a better ethical and moral foundation for healthy adult sexual adjustment. Churches, health services, social agencies, and youth organizations should contribute to parental and school efforts to teach them physical and emotional growth, sexual development, courtship, marriage, and parenthood with emphasis on personal integrity and family responsibility. The past emphasis on the possible deterrent effect of fear of venereal disease and pregnancy is made less tenable by the availability of antibiotic and oral contraceptive medication.

The American Public Health Association further urges state and local health departments to strengthen such elements in their cooperative activities with schools and other programs and to support adequate training of personnel for such work in their own and other agencies.

Dr. GENDEL. I was going to say that a former colleague of yours, Congressman William Roy——

Mr. MEEDS. If I may interrupt, a very valued former colleague.

Dr. GENDEL. We used to travel the public school circuit together, discussing health issues with the students in Topeka and the surrounding areas of the Grant circuit court that you can make in Kansas, another great State. I am a transplant, but I feel that way about it.

We both did that because of some of the things that are being said here in this bill. Various people took on the role of health educators, simply because there was no comprehensive school health program, yet it is such an important part of any of our concerns for health care today.

I am concerned as a physician, because we are talking mostly, when we refer to the health care system, to an illness care system. I would like to get to a point on that a little bit later.

I would like, a this point, to share some thoughts with you that are shared also by the members of the association that I represent, the American Public Health Association, in which there are 50,000 regular and affiliate members. I think that most of you are familiar with that organization. We have 50,000 regular and affiliate members who encompass a broad spectrum of health and health-related disciplines, including a substantial number of health educators working in a variety of settings in the school health section.

The American Public Health Association as well as the public health educators are all part of this group. We have been working on a concern for school health education for a long time, and in 1974 at the 102d annual meeting of the APHA in New Orleans, a position paper on education for health in the school setting was presented, and adopted by the governing council, and a copy of that is attached to my statement. I will not read that at this point.

In view of the high priority that my organization attaches to health education, I think the most important thing I want to say to you is that we appreciate the fact that this legislation is now available before the public and the Congress, and has support in both Houses.

A lot of things that have been said so far are those that appear also in our statement. I think the fact that the community setting reaches such a large number of young people who are hungry for information about themselves.

One of the things that Len and I have discussed in the past on the valuing of health, is something that I have learned from patients the hard way. Opportunity to counsel with the patient when you are in private practice is usually in an illness setting, rather than the setting which I would call the appropriate setting of where young people spend their years from Kindergarten through 12. I think that this is what we are talking about as a comprehensive program.

It has not happened in the past, and I guess you would have to characterize it by saying: We have episodic campaigns in school information about what I consider current and recurrent fears. These are fears of cancer, pollution, unwed pregnancy, measles, polio, overpopulation, and you name it. They have all surfaced at various times, primarily because of the sense of guilt by those of us who know the dangers and the problems, but are unable to create any public awareness, which is, I think, what this bill is trying to do, until large segments of the population are affected, or when epidemics occur.

Whenever that happens, as with drug abuse, when it leaves one area, and gets to the more general population, then there is a lot of funding, personnel, special funds, and then we relax, and we think that the problem has been taken care of. Then, it recurs again in a cyclic fashion 5 to 10 years later.

I think that the exciting thing about this bill, and the important thing is that rather than saying that fresh programs of health education are a panacea for a problem, we are trying to say that a comprehensive program can establish some solid foundation for thinking about one's self, and value in one's self. Unless that happens, value in health is not likely to occur.

The other thing is that comprehensive school health education has really never been tried, ever, on a full scale and on a continuum, not only through the school years, but we would hope throughout the life cycle.

The other part of the major concern is that there have to be some new solutions, and also a return to some of the older concept of an approach, which is the epidemiological approach. Many of our problems are related to life styles, for instance, the opportunity to make choices about one's life style through the dissemination not only of information, but the internalization of the learning process itself, has to be emphasized.

We can use the epidemiological approach to find out why these things occur, rather than attacking them after the symptoms occur.

We are also concerned about the soaring cost of medical care for treatment, rehabilitation, recuperation and restoration. There is no question in the American Public Health Association, and all of those in schools who are interested in prevention that primary prevention

is something quite different than secondary prevention. That is where education is to me, and to those that I represent, one of the major tools for solving and preventing personal health problems. They concern not only the individual, but the environment, and the provision of care for the whole population.

If individuals know how to enter the health care system, they become health activated citizens—I do not like to call them consumers, because once you are a consumer it means that you are already in need of care. Hopefully, the kind of health education, or education about health that we have would be what would help us to understand how to stay well, maintain health, and be more than just without disease. In other words, optimum health, and learning to take care of our own families.

I think the scope of health education as defined in the bill provides for that kind of comprehensive school health habits from the elementary school grades on. I think that the part that specifies the purposes of the grants is tremendously important, because if teachers feel ill-prepared and insecure to talk about health, there has to be an input, such as you have designed for implementing this part of teacher training.

I think there is one other area that I would like to address, which perhaps has not been addressed, and that is the inadequacy of the health education as it relates to, or is relevant to the urban population, poor population, the minority population.

There has been a recent analysis of minority related content in 20 college health texts, and those are the very books from which many teachers learn, and acquire their learning about health. The references really display a massive neglect of the minority concepts, the ethnic background, which will help, as they are multifaceted, and they are what the health educator needs.

I think the portion of the bill in which you mention the strengthening of education in family life and human development for the total population, and particularly in the area in which I work, maternal and child health is of tremendous importance, and is evidenced, as you know, by the growing rate of pregnancies among teenagers, and the high divorce rate, especially for those couples who marry at young ages.

It is extremely important that the physical aspects of human growth and development be integrated with the psychological aspects.

Preparation for responsible parenthood is increasingly needed. I think young people are hungry for the opportunity to have and to learn what that responsibility really means. I think we have to remember that the word "responsibility" has the word "response" in it. The young people know what their responses are, but sometimes they don't know what to do with them.

I don't know that we, as adults, are in an appropriate position to tell them what to do with them, primarily in view of our behavior, our model behavior, such as Len was talking about.

Ignorance is never better than knowledge. Knowledge is better than ignorance. It is what we have all been dedicated to, all the organizations that are represented here today, and certainly the whole learning process.

The other point that I referred to earlier is the need for health education to develop informed health. We say in the testimony here "health consumers," and "health citizenry." What we need is the comprehensive school health education programs, those total programs that you are advocate, which are the ones, I believe, that can engender that kind of thinking in the American public, something that we have not done before, which is doing to become more and more important, not only as an economical but humanitarian effort.

I don't think we need to underplay that humanitarian need, because that encompasses economy as well as the well-being of all families.

I know that there are a number of other things that I would like very much to include. They are included in the statement, and I would be very happy to respond to questions. I certainly appreciate the opportunity to appear before you this morning.

Mr. MEEDS. Thank you very much. Dr. Gendel. I have not had the opportunity to read your entire statement, but what I have read, and from listening to your testimony, I am very impressed with your grasp of the subject matter. Indeed, you have hit in your statement almost all of the rationale behind this bill.

I am particularly struck with your statement on 5 and 6 with regard to the inadequacy of the present teacher preparation curriculum. I point out to you, as a preface to my question, that this is a developmental bill. The first 2 years are development.

I think you probably agree with me, do you not, that if you were to take $100, $200, or $500 million, and spread it across the country today for health education, that it would probably not be very well spent.

Dr. GANDEL. That is probably true, because we have a need for teacher preparation. We have some excellent pilot model programs, to which a number of people have referred, but they are, perhaps, in one small area. If they can act as the crystal from which others can grow in a development fashion, this is a very exciting prospect.

Mr. MEEDS. This recognizes the kind of basic, or ground work that has to go into this program before the outright grants for health education are forthcoming.

Dr. GENDEL. I think it is important for all of the committees to know how much individual States, and in our State, for example, we cooperate very much with the Department of Education, with private groups, the State medical association, in the very kind of thing you are talking about, discovering what the needs are per State.

They sometimes lap over with other States, I recognize that. We have the rural population, the metropolitan and overly populated areas. Yet, the underlying threat among all of them is the need for this comprehensive type program, and it begins with teacher training.

Mr. MEEDS. As you point out, there are vast differences with health education, and how it is taught in various areas. We need to develop a lot of different curricula. One set of curricula which is developed for the ghettos is not going to suffice in suburbia. It has to be a different approach. Is that correct?

Dr. GENDEL. It would have to be a blunted approach. One that can approach the people who are moving from one place to another, and

have a mosaic of the population represented in the classroom, so that we meet all the needs.

Mr. MEEDS. Finally, if I got the purport of your testimony on page 3, you indicate that a lot of health problems today are really cultural.

Dr. GENDEL. Yes.

Mr. MEEDS. We need to be talking about our lifestyles. These are the things that are not being examined in any crisis oriented health care, or health system which we have, which you point out in another place in your statement. How do we really get at this question of cultural disease?

I like your statement "You cannot immunize." How do we get at it, Doctor?

Dr. GENDEL. I think that part of it is learning how or what the inputs to families are, speaking strictly to their health. I had developed previously, and shared with some others, the fact that the family beliefs and practices, what happens within the family as part of their social pattern and beliefs, are the beginnings of those life styles.

They vary from person to person. We need more study in that area, what I call the epidemiological approach, to see why certain beliefs result in certain kinds of lifestyles. That we have a peer group education that goes along with the particular groups in different areas.

Finding out, to me, the benefits of that peer group education. So often we play that down. We, as adults, respond to peer groups education. We don't rush to the library, or go to the nearest expert to get information. We develop our habits out of our own lifestyles, and in discussion with people who are our own colleagues. It it not always good. Then, there is the mass media.

Mr. MEEDS. What you are pointing out here, if I am hearing you correctly, is that outside of the home itself, which is the basic unit and most important, the 17,000 school districts across this Nation is the next place that has the best opportunity to do something about this cultural disease.

Dr. GENDEL. That is correct. Captive audience is always thought of in a negative way, and I am thinking of it in a positive way.

Mr. MEEDS. We have a wonderful opportunity here in the 17,000 school districts to enlighten people about some of the health problems, which they develop later, or are developing now, which they don't even know about.

Dr. GENDEL. I think, when I mentioned the cultural problem, it was simply that the school would not necessarily change that, but that the health education would be geared to building on those knowledges and beliefs in a positive way, instead of in a neglectful way, as we have done in the past.

Mr. MEEDS. Thank you very much.

The gentleman from Illinois, Mr. Hall.

Mr. HALL. Other than to say, as a former teacher, I think you have put the meat on any curriculum, and have closed the door on any classroom. I think the key here may be in teacher training. I know that it is sadly neglected. I know that we have had also 15 or 20 years of courses, for lack of a better term now, of sex education. It seems like the teenage pregnancy rate is going up, and it is continuing to

increase, at least those classes in the past have not been very successful.

What would you suggest? I see kind of an interweaving here. What in your view is the key?

Dr. GANDEL. The key, of course, is in sex education. That is again the fragmentation that we have been talking about. Sex education is a course in one aspect of a person's health, whereas education about sexuality really ought to be a part of learning about the totality of self. You don't leave any part out. No part is shameful. So, if you are going to talk about the total human being, you talk about education about sexuality, but not as a separate program, but as part of the integration of the growth and development.

It comes into various other areas throughout learning, about parenthood, all of these things. Responsible parenthood cannot be taught, unless we know some of the basics of our own physiological response.

To become emotionally and biologically prepared at the same time would be nice. What happens is that young people become biologically prepared before they become emotionally prepared to deal with their own physiology.

It is important to know ahead of time what you are dealing with, and that is a very strong help in coping with problems, knowing that you are not the only one, and that it is part of your total health picture, and not to be separated out from the rest, any more than separated from the rest of life and living. Perhaps we have done that too much in this country.

Mr. HALL. I guess that most of you have read the recent court decision about the gym teacher in California who had posed for the girlie magazine in the nude. The court said that he could not be dismissed from his job because of that.

I wonder where we are headed sometimes. This man was more concerned about getting money for a trip to Hawaii by posing for this picture than he was about the impact it might have on both boys and girls who are in his school system. That is another question but I wanted to get this in the record.

Mr. MEEDS. If the gentleman would yield, I might point out that maybe he should have attended a course in discretion.

The gentleman from Oklahoma, Mr. Risenhoover.

Mr. RISENHOOVER. I have no questions. I would like to observe that I am sorry that this bill is not broad enough to cover some extensive adult education also.

Mr. MEEDS. Hopefully, that process will work also with this bill.

Dr. GENDEL. With your permission, Chairman Meeds, on what was just said, one of the best feedbacks from programs in which the Bureau of Maternal and Child Health has been involved with the Department of Education, and I think that this is the kind of thing that the Departments of Education and Public Health people do together quite a bit, is the feedback that you get when you have a comprehensive health education program, in terms of educating the adult population.

The kinds of questions and issues that the young people bring home, I think we have never given them enough credit for what they do. Certainly my five have brought home a lot of provocative ques-

tions about how we value our own health. That begins to educate parents.

I believe that everyone who has young children, they will have them question their smoking habits, and wonder what they might do about that. That is education itself.

Mr. MEEDS. Thank you again, Dr. Gendel, for an excellent testimony.

Dr. GENDEL. I appreciate being invited very much.

Mr. MEEDS. One announcement before we adjourn.

Mrs. Herndon would like you to stay for just a little while to discuss another matter after we adjourn. You may have this room for your discussion.

Second, we will commence again tomorrow morning at 9:30 and hopefully we will be able to go on through uninterrupted at that time.

Again, I want very much to express to all of you my appreciation for changing your schedules to accommodate the U.S. House of Representatives. We all appreciate it very much. Thank you for your attendance. Thank you all for your testimony. We will adjourn now until tomorrow at 9:30.

[Whereupon, at 9:45 a.m., the hearing adjourned, to reconvene at 9:30 a.m., Thursday, March 13, 1975.]

[Material submitted for inclusion in the record follows:]

AMERICAN LUNG ASSOCIATION,
New York N.Y., March 12, 1975.

HON. CARL D. PERKINS,
Chairman, Subcommittee on Elementary, Secondary and Vocational Education, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN PERKINS: The American Lung Association wishes to record its support for H.R. 2599, a bill to provide Federal support for school health education programs. Federal funds for these programs are long overdue and are certainly key to effecting change in the present unsatisfactory school health situation.

Early in its history, this organization, then the National Tuberculosis Association, realized that education of children in hygienic practices was closely involved with improving control of TB. However, the commitment of TB–RD associations to school health extended beyond that level to promotion of healthful living in general. Through the years our associations in various parts of the country have been in the forefront in assisting school systems with their health programs.

Unfortunately, efforts have been of limited value because funds were usually insufficient or were misdirected. There are various reasons for failure in the present environment of health education classes.

Where classes are provided, they are often make-shift arrangements and teachers are poorly trained in the subject of health education. More important, perhaps, these programs are not under the supervision of anyone responsible for or interested in integrating the health programs being taught at the various grade levels.

Instructing children does not necessarily motivate them to carry out what is being taught. There has been little attempt to use innovative techniques and tools in teaching health education. The need for modern methods is great. It is our conviction that efforts will not be productive without a considerable infusion of new ideas and methods of teaching. The example of how science education was revolutionized to become a dynamic learning process which "turned students on" has important implications for the future of school health education.

There is little effort exerted in the early grades to orient children to health maintenance; programs are usually directed at older children whose patterns of living and philisophy of what is important are already established. Children should be alerted when very young to the values of healthful living and the

need to be concerned with and responsible for one's own health. Our organization's close involvement with efforts to discourage children from smoking makes it especially aware of the need for attention to formation of health patterns as early in life as possible.

So far as H.R. 2599 is concerned, we consider the authorizations minimal in view of the numbers of states and school districts to which funds would be distributed. Section 6, which provides for implementation of programs, appears to us to be the most important section of the bill, especially if the authorization can be increased, the program can become operative earlier, and be fully funded.

It is especially important that monies not be dissipated in administrative expenses. Activities of the past, concentrated mainly on training and curricula development, have had negligible influence on school health programs. It is for this reason that we believe that to be productive most funds must be spent in the classroom.

Good school health programs are especially important in a climate of rising medical costs. Our ability to prevent many degenrative diseases which are leading killers is admittedly limited especially when compared with the potential in the area of communicable diseases. However, the knowledge that is available to us certainly implicates social and nutritional habits.

With increasing emphasis on the importance of prevention in proposals for national health insurance and in government financed programs already underway to increase efficiency and lower costs of medical care, it is important that we start as early as possible with preventive programs. It is our hope that Federal funds will become available in sufficient amounts to finally make this approach possible and effective in schools throughout the country.

We hope that our observations will be of help to your committee during their hearings on this bill.

Yours truly,

GERALD R. RISO.
Managing Director.

RALEIGH, N.C., *February 24, 1975.*

Hon. IKE ANDREWS,
Congress of the United States,
Cannon House Office Building,
Washington, D.C.

DEAR SIR: It is our understanding that *H.R. 2600–Comprehensive School Health Educaton Act* has been referred to the Committee on Education and Labor, of which committee you are a member.

We urge support of this most important, far-reaching bill. As you know, North Carolina has a high rate of heart disease, hypertension, diet problems, etc.; and education of our children re lifestyle and better diets to help prevent some of these problems in the future is most urgent. This bill will help greatly.

Recently in *The News & Observer* the results of a study by the U.S. Department of Agriculture were given: "DIET CUTS ILLS. Washington—*Improved nutrition* can reduce arthritis, dental problems and diabetes by 50%, alcoholism by 33%, eye problems by 20%, heart problems by 25%, and cancer by 20%." If time (research) and money (tax dollars) were spent on gaining this information, then surely the results should be acted upon and soon. Better nutrition and more education, of our young especially, on all the health areas included in H.R. 2600 under the term, "health education and health problems," are needed in our State. Therefore, please support H.R. 2600 so it will soon come out of committee and go on to pass, hopefully, this session.

Sincerely,

JOSEPH L. CUDDY.
PEGGY S. CUDDY.

EAST TENNESSEE STATE UNIVERSITY,
Johnson City, Tenn., April 23, 1975.

Hon. CARL D. PERKINS,
Chairman, House Committee on Education and Labor, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN PERKINS: I am writing this letter to enlist your full support and positive action on one of the most important and vital pieces of

legislation concerning the health of our people. I refer to H.R. 2599, the "Comprehensive School Health Education Act," which has been referred and is now before the Committee on Education and Labor of which you are Chairman.

This Act, sponsored by twenty-one outstanding Congressmen, is a positive approach to one of our most neglected and yet most important parts of our educational program. A real and genuine school health education program would overcome, eliminate or prevent many of our health problems. It would change our negative approach where we spend the majority of our time planning and thinking about sickness and the care that is needed because of disease, the results of disease and our national disgrace—accidents to a positive approach of planning and educating toward prevention and the correction of defects.

H.R. 2599, the "Comprehensive School Health Education Act, offers refreshing hope and I strongly and sincerely ask for your full support of this legislation.

Sincerely,

JOHN P. LAMB, JR.,
Dean, College of Health.

AMERICAN NURSES ASSOCIATION, INC.,
Kansas City, Mo., April 16, 1975.

HON. CARL D. PERKINS,
Chairman, House General Subcommittee on Education, Committee on Education and Labor, Rayburn House Office Building, Washington, D.C.

DEAR CONGRESSMAN PERKINS: The American Nurses' Association appreciates the opportunity to submit its views regarding, H.R. 2599, the Comprehensive School Health Education Act. We especially commend the committee for recognizing and considering the urgency of a legislative proposal that could assist in providing the opportunity for each school-aged child and adolescent in the United States to develop to his or her fullest potential.

We believe education for personal health and health citizenship assists the individual to make his or her maximum contribution to the welfare of his or her community and country. Advances in health sciences can only be utilized when people are properly informed about them.

There are approximately 30,000 registered nurses who provide school health services either on a full time basis or as a part of their responsibility for health care delivery. In many instances, this is the only opportunity the school child has for contact with a health professional or with health education.

In 1973, the ANA and the American School Health Association issued a joint statement, "Guidelines for the Nurse in a School Health Program," which is now being revised in collaboration with the National Educational Association, Department of School Nurses. The Division of Community Health Nursing Practice of the ANA has a committee on School Health and twenty-nine state associations have conference or special interest groups for school nurses.

Historically school nurses have provided health teaching, health counseling and consultation to students, parents, faculty and school administration. In addition they have provided direct health services to students.

The role of the school nurse has expanded to include the school nurse practitioner who can identify and assess the factors that may operate to produce learning disorders, psychoeducational problems, perceptive-cognitive difficulties, and behavior problems, as well as those causing physical disease. School nurse practitioners are prepared to assume more initiative and to accept increased responsibility and accountability for their acts. The recognition and acceptance of medical, nursing, and educational collaboration permits the potential of each discipline to be used more effectively in improving the health care of children and youth.

In many schools, health education programs are fragmented and crisis oriented to meet a current need, such as veneral disease, drug abuse, etc. The American Nurses' Association promotes and supports a unified, integrated, sequential approach for comprehensive school health education programs, grade K through 12.

Development and evaluation of comprehensive programs in elementary and secondary schools for health education and health programs necessitates interdisciplinary efforts. A special need is for the interdisciplinary approach in

which the school nurse, physician, dentist or other health professional combine their knowledge and skills. Thus, these health professionals in a consultative role along with the school faculty can bring about a curriculum and teaching program which meets the needs of the student. We would especially encourage the consideration of the school nurse as eligible for teacher training programs so that she/he may have the opportunity to update his/her knowledge and skills and therefore be considered as a school health educator.

We thank you for the opportunity to present our views on H.R. 2599 and would be pleased to assist the committee at any future date.

Sincerely,

ROSAMOND C. GABRIELSON, M.A., R.N.,
President.

TOPEKA, KANS., *April 14, 1975.*

Hon. ALBERT H. QUIE,
U.S. House of Representatives,
Washington, D.C.

DEAR CONGRESSMAN QUIE: As a member of the Executive Board of the American Public Health Association, and, personally, I appreciate your follow-up questions to those who, during your recent hearings, presented documentation for support of the Comprehensive School Health Education Act. They are pertinent questions and issues which I have tried to answer out of experience in private practice both as a general practitioner and as a specialist in orthopedic surgery, as well as in public health.

After a short period of time in public health, I "woke up" to the unique responsibility the profession offers in instilling in people the long range benefits of learning to value onself by valuing one's health *prior* to becoming ill. So I stayed in public health for the long term rewards of not only preventing at least catastrophic problems (epidemics, VD), but also of aiding at health activated citizenry participate in health care (not illness care) decision-making.

I have tried to answer as straight-forwardly as I could, the questions which you have so thoughtfully posited to me. Attached are some documents which, I hope, outline some of the issues more thoroughly. Please feel free to contact me if I can be of any further assistance.

Most sincerely,

EVALYN GENDEL, M.D.,
Director, Division of Maternal and Child Health.

Enclosure.

Question 1. Have you examined the Special Projects Act, section 402 of P.L. 93-380, as a possible area for funding? Would the purposes of the Special Projects Act be consistent with what you believe should be a Federal role in health education?

Answer. The Special Projects Act does not cover the issue in any specific way that is needed in a consistent continuum of knowledge of education about health.

Question 2. It is clear that the Administration is against new categorical programs. How successful can a new categorical program be in terms of implementation under the direction of an Administration that is opposed to it?

Answer. Health education, by definition, is not a categorical program. In fact, health education strives to overcome categorical programs, which usually are instituted to meet special interests, or social (current) health issues, and attempts to establish a framework within which all health issues and subjects can be viewed. Education about health (comprehensive shcool health education) permits such an ongoing framework to develop.

Question 3. Why do you believe that health education should have a higher priority in the expenditure of Federal funds than, for example, funds for the handicapped or the educationally disadvantaged?

Answer. Since medical care (illness care) costs are one of the major budget items of the federal government—and since a great deal of monies have been poured into this system without spectacular curative results—it would now seem appropriate for the federal gov't. to invest in creating a mechanism for stimulating *health aware/activated citizens* and in placing much greater emphasis on the preventive aspects of medicine.

Question 4. Do you believe that health education should have a higher priority in the expenditure of Federal funds than, for example, funds for the handicapped or the educationally disadvantaged?

Answer. Yes. This may sound insentive—but with the statement *first* that I do not believe it should be an either/or situation. But if it were to *have* to be (and I do not see the comparative relationship) a choice—general health education would affect a much larger population, and could help define prevention of future handicapping conditions.

Question 5. Since the Comprehensive School Health Education Act overlaps with a number of other programs already in existence, would you support the termination of those programs so as to provide preferential funding for this bill?

Answer. Again—I don't see the either/or choice—but I do believe all such programs could be reviewed and, where possible, could be integrated into a comprehensive school health education continuum.

Question 6. Health education is an area that spans two very important areas of public concern, the provision of health services and public schools. Might it not be better to tie the provision of health education to the health professionals rather than the schools?

Answer. As a health professional, I have a positive belief in the need for very early introduction of health awareness to all future citizens, the designers and users of health care in the next generation or two. The schools provide an ideal setting to begin this process through the utilization of a wide variety of personnel, from the fields of both health and education.

Question 7. A great deal of attention has been given in recent years to the establishment of HMO's (health maintenance organizations). One of the purposes of an HMO is preventive medicine. It is my understanding that the law estiblishing the HMO program does require patient education services. In addition, four other health programs require through administrative regulation the provision of patient education programs. Those programs are community health centers, migrant health centers, maternal and child health programs, and the Health Service Corps. Since the concept of comprehensive care through HMO's is flourishing in many areas of the country, does it not make a good deal of sense to have health education programs provided through the health delivery structure so that it is more directly related to those who provide the services?

Answer. Patient or consumer education about health described above is almost mandated to be given in a "sick care" setting—in other words, once you or I or the individual become a "consumer" we are already ill in the first place. So, of course, patient education, in whatever institutional setting it *can* occur, it *must* occur to prevent further illness. But this kind of doctor/patient or institution/patient education does not reach the citizenry at large, who may be happily well, or part of the "worried" well, but not yet sick. This individual generally will not seek "health" (sick) care until sickness occurs. We should encourage, within the HMO setting, this kind of health education for this latter group as well as for our sick population. Since the HMO and the other programs you describe focus on prevention and comprehensive care, they represent an ideal location for these services. They are *not*, however the only possibilities, for we should also look to locations which offer opportunities to educate people but which are not specifically identified with health, like the schools, factories, churches, etc.

Question 8. Do you think that health education is really best handled in the school, or is it more properly handled in the home, by doctors and dentists, etc.

Answer. Part of this question is answered under #7—but to clarify further: dentists, doctors, nurses and health professionals of any type, reach only those who come in contact with them, or with highly informed family members. This amounts to an incidental, even accidental, model of health education. The schools represent a "captive" audience which includes all of the student population, sick *and* well. It does not however, exclude continuing education or reeducation of adults or of anyone *not* in the school programs, who can be reached in some of the other locations mentioned above.

Question 9. Do we really know how to teach in the classroom such delicate subjects as human development, mental health, and substance control? Is it not more likely that young people would react more positively to health edu-

cation if it were taught in the context of the health care system rather than in the context of the schools?

Answer. This question picks up on some of the points in 6–7–8—but raises another point—"teacher preparation in health." So-called *delicate subjects* are part of life and living for every individual at some time and therefore, by definition, part of the educational process, if we believe that knowledge is better than ignorance. Teacher preparation is already addressing these issues because students are constantly raising them. Unless we stop believing that education is helping students to "live" better *in the future* and change to a definition that they are "living" now—we will lose many of them to the educational process altogether. The section of the proposal on teacher preparation is *most* important—and *that* is where the health professional can make a valuable input as a resource person, but not as educator or classroom "visitor" for special subjects.

Question 10. Do you have any evidence on the effectiveness of health education programs? Do you find that students really pay attention to them, or are they just another requirement that they must sit through?

Answer. This subject makes health education appear as a subject in learning which must be "proven" effective in order to be given support, even though this is *not* required of other subject areas. For instance language/reading skills of students now entering college are lower than they have ever been, yet no one is suggesting that English or reading or literature be dropped from education—instead (and rightly so) we strive to find methods to improve the learning process in these areas. Similarly—American Government or History have not accomplished the one single measurable goal available to them: an increase in voter registration levels. Rather, the percentage of voters is less than ever in history, but no one is suggesting dropping the requirement for American Government from the curriculum or even using voter registration rolls as a long term measurement of such courses, program and/or curriculum.

Question 11. You propose a special curriculum in health education. There are those who would argue that health education should be spread throughout the curriculum to make it more helpful and more meaningful. How do you feel about that concept?

Answer. I have never been an advocate of separate course and/or programs in health education, as long as there was a *planned* system of integration of health areas in programs which touch on health (biology, physiology, family life, physics, chemistry, etc.) The haphazard of repetition in each of them, which is how it is often presently offered, bores students or makes them feel there was no coherent relationship between these subjcts. Therefore, curricula in health education *must* be tailored to what already exists and be planned for what does not exist in order to provide the broad spectrum to individual communities and their schools.

SCHOOL OF PHARMACY,
THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL,
Chapel Hill, N.C., April 8, 1975.

Hon. L. H. FOUNTAIN,
House Office Building,
Washington, D.C.

DEAR MR. FOUNTAIN: I am writing to you in regard to a bill which was recently introduced by various representatives. This bill is entitled the "Comprehensive School Health Education Act" (H.R. 2599). This bill offers perhaps the best approach to not only drug education, but the entire health education area.

Despite the many piece-meal and often counter-productive bills which have been passed in recent years to combat drug misuse, this approach at comprehensive health education seeks to place drug use in its proper perspective, thus decreasing drug misuse as well as other types of harmful behavior.

I would urge your support of both this important concept in health education, as well as the rapid passage of this important bill in providing vital assistance in this area which has been largely ignored in the past.

Sincerely,

STEVEN R. MOORE,
Associate Director.

COMPREHENSIVE SCHOOL HEALTH EDUCATION ACT

THURSDAY, MARCH 13, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ELEMENTARY, SECONDARY,
AND VOCATIONAL EDUCATION OF THE
COMMITTEE ON EDUCATION AND LABOR,
Washington, D.C.

The subcommittee met at 9:30 a.m., pursuant to call, in room 2261, Hon. Lloyd Meeds presiding.

Members present: Representatives Perkins, Meeds, Mottl, Miller, and Goodling

Staff present: John F. Jennings, majority counsel, and Christopher Cross, minority legislative associate.

Acting Chairman MEEDS. The Subcommittee on Elementary, Secondary, and Vocational Education of the Committee on Education and Labor of the House of Representatives will be in further session for the taking of testimony and hearing of evidence on the bill H.R. 2600 and other related bills.

The first witness of the day is Lucille Trucano, assistant in health education for the Seattle School District, Seattle, Wash. Please come forward, Lucille.

I might say by way of introduction that Lucille and I are longtime friends, that she is a longtime friend of health education, coming from a State which has a good history in health education, with a fine director in the person of Carl Nickerson at the State level and fine people at the local level like Lucille.

We are delighted to have you with us this morning, Mr. Chairman. The chairman of the full committee is here.

Chairman PERKINS. Let me say to your distinguished witnesses from Washington, that your friend who is the chief sponsor of this legislation in the U.S. Congress, has been pushing for several years to get legislation on the statute books.

I personally feel because of his perserverence and untiring efforts in this connection that he will be successful this year, and he commands the respect of all the people in the Congress and all the people on the House Committee on Education and Labor.

The hearings that he is presently conducting will be outstanding on the need for the comprehensive health bill at the multisecondary level. I am delighted to be associated with Congressman Meeds in supporting such a comprehensive piece of legislation for schoolchildren, something that has been long needed and long neglected.

I just want to associate myself with the remarks of Congressman Meeds complimenting you for paying your own way from the great

70-980—76——5

State of Washington here to the Nation's Capital to put in an appearance for better health for the schoolchildren.

You can be proud of your Congressman in pushing this legislation. Go ahead.

Acting Chairman MEEDS. Thank you very much, Mr. Chairman. Lucille, how can you top that?

Ms. TRUCANO. We are very proud of Mr. Meeds, by the way, Chairman Perkins.

STATEMENT OF LUCILLE TRUCANO, ASSISTANT IN HEALTH EDUCATION FOR THE SEATTLE SCHOOL DISTRICT, SEATTLE, WASHINGTON

Ms. TRUCANO. Chairman Perkins, Congressman Meeds, and members of the committee, I am very honored and appreciative of this opportunity to present testimony on the Comprehensive Health Education Act on behalf of Dr. Frank Brouillet who is our State superintendent of public instruction.

Acting Chairman MEEDS. I have Dr. Brouillet's statement and without objection it will be part of the record. You may proceed.

[Prepared statement of Dr. Frank Brouillet follows:]

PREPARED STATEMENT OF DR. FRANK B. BROUILLET, WASHINGTON STATE SUPERINTENDENT OF PUBLIC INSTRUCTION

This testimony is in support of HR 2539, The Comprehensive School Health Education Bill, and the related appropriations. First, I wish to commend the leadership of Congressman Meeds and his many colleagues for introducing and sponsoring this bill.

Today's concept of health *is* a state of well-being—physically, mentally, socially, and emotionally. It is more than not being sick—it is having a zest for life. It is possible in today's world, with the knowledge available, for each individual to make decisions which would allow him/her to function at a high level of well-being.

However, people do not acquire a high level of well-being by chance. If the nutritionist has something to say to help people attain well-being, if the physician has come upon something he wants others to know about, if the geneticist discovers a new factor in heredity, then somehow people must be taught these things. The only way to get the job done in anything but a haphazard way is for society to demand that its educational system rise to meet the need.

Although education cannot do everything, at no time in history have so many people believed that education is man's greatest hope. The United States marshalled its forces in science and mathematics to compete with Russia for the conquest of space. There is no reason why American education cannot follow that example to disseminate knowledge and develop decision-making skills which would enhance the quality of life and allow individuals to function at their optimum health.

Our forefathers insisted that education be a part of this developing country. Health was among the objectives of education from the beginning. The seven cardinal principles of secondary education included health as a desirable outcome of education. White House Conferences on Education recognized it, the Education Policies Commission endorsed it, and the American Association of School Administrators blessed it.

Our nation may have "bought" the educational objectives of producing healthy effective people, but no one "paid" for it. Therefore, as with most things that are taken for granted, individuals and the nation are paying for it in other ways. There is much ignorance of that which is known about health, much waste of human potential, and far too much preventable diseases. A major cause for much of this condition can largely be attributed to the fact that comprehensive school health education has received little, if any, priority at any level of government. An overwhelming majority of funding and personnel

allocations related to health are directed to treatment and rehabilitation rather than prevention.

"Of $18.2-billion allocated in 1973 for medical and health activities of the Department of HEW, only $30-milion is for specific programs in health education; $14-million more for general programs. That amounts to less than one-fourth of one percent. Of $7.3-billion allocated for health purposes to all other federal agencies, even a smaller fraction is spent on health education.

On the state level, health departments spend less than half of one percent of their budgets for health education.[1]

There are 50 million youngsters in schools of this country who are the adults of tomorrow. Goethe, the German philosopher, said, Little can be accomplished for the grown-ups. The intelligent man begins with the child.

An overwhelming majority of our nation's schools do not have comprehensive health education taught by qualified instructors. Two significant studies[2 3] completed within the last ten years indentified a variety of reasons for the void of sound health education programs; the Comprehensive School Health Education Bill addresses itself to these reasons.

One of the identified factors for inadequate programs was the lack of qualified people teaching health education. Not only do individuals who teach health education need to be knowledgeable in the biological and behavioral sciences, they must also be mature, healthy people themselves. They must be aware of the interrelated health factors having an impact on their students and must be able to assist each student learn the skills necessary for optimum health. HR 2599 provides for upgrading the quality of preservice and inservice teacher preparation.

There are many pressures on schools of today to include categorical topics because education has a captive audience of over 50-million children. In the field of health, proponents of over 30 categorical topics have pressured schools for inclusion (i.e., smoking, venereal disease, nutrition, cancer, accident prevention).

The Joint Committee of the National School Boards Association and the American Association of School Administrators stated that there is neither time nor justification for separate courses in any of the categorical areas advocated by specialized interest groups. Health is a unified concept. It must be approached with the consideration of the total human being and the complexity of forces that affect health behavior.

The most effective and efficient way for schools to fulfill their responsibility in meeting the health needs of students is to develop a comprehensive health education framework in which all topics find a place and are logically interrelated. One sound, sequential program saves time in an already crowded curriculum. More important, it assures that all topics will receive complete consideration at the appropriate levels. A further argument for a comprehensive program over categorical programs is the fact that any health topic should not be taught in isolation; it relates to all others.

A comprehensive program would insure that what we know about learning is utilized. A single exposure to a health concept without reinforcement at other grade levels or without a chance to see how one factor affects another factor would indicate that the program does not utilize knowledge of the learning process. Positive learning takes time, interrelationship, reinforcement, and careful planning. The problems of venereal disease or abuse of alcohol, are not just V.D. or alcohol abuse but problems also concerned with values, self-concepts, peer pressure, and skills of decision-making. Program planning must blend with knowledge about young people, society, learning principles, and health. Thus, sections 4 and 5 of the bill are critical.

Many segments of school health education programs are already in existence in some states.

Florida, New York, Illinois and other states have recently passed health education legislation.

Most states have developed health education curriculum guides or guidelines. The Washington, Oregon and Wisconsin departments of education are currently

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[1] The report of the President's Committee on Health Education, R. Heath Larry, Chairman, pgs. 11–12.

[2] School Health Education Study: A Summary Report, Elena M. Sliepcevich, Director, 1964.

[3] Op. cit., The Report of the President's Committee on Health Education.

sharing resources to develop a cooperative health curriculum guide and supplementary resource materials.

Some states have developed plans for improving school health education. In January, 1974 Washington State completed such a plan (see Exhibit A).

Some local districts have pilot or demonstration projects in categorical health programs, i.e., nutrition, drug abuse prevention, health careers, smoking, and others.

Many districts have some teachers who are excellent health teachers.

It is paramount to note that although the items listed above are positive components, they do not indicate that comprehensive school health education programs exist in our nation's K–12 schools. Passage of state legislation does not insure needed funding; curriculum guides do not insure classroom programs; plans in themselves are not programs; a categorical demonstration project is not a commitment to a comprehensive program; and a few excellent health teachers can not fulfill each child's right to the kind of sequential education program that will assist them in their pursuit to a healthful life.

Priority and funding assistance are needed from Congress and the President to support states in providing the necessary resources to make quality health education a reality in every child's school experience.

State education agencies are in a strategic position to provide two way liaison between federal programs and local school district needs. In addition to many other capabilities, they are in a position to report results of specific programs directly to members of congress.

It is reassuring to note that the author and sponsors of this bill have seen fit to include a prominent role for state educational agencies. It should also be recognized that many state educational agencies have been providing some leadership in health education. For example in Washington we have supported a full time supervisor of health education since 1966. In addition, this year we are utilizing Title V, ESEA funds to support an administrative skill training program in health education and to develop a model junior high program in a local district.

Funds appropriated as a result of HR 2599 will be quickly converted into programs for children in Washington and other states which have already been utilizing limited state funds for health education leadership. Other states will be stimulated to move into comprehensive health education leadership with the help of congress in passing this legislation.

The fact that history has been made with the introduction of the first comprehensive school health education legislation has already created a great interest and excitement throughout the states. Two concerns must be expressed about the administration of this bill even at this early stage.

1. Adequate safeguards must be established to insure that the intent of Congress is followed in the administration of this bill.

2. State Education Agencies should have input to major policy and program decisions *before* finalization.

In almost every subject area where great curriculum reform has occurred, there have been several common elements behind the movement: dynamic leadership, public concern, a renewed commitment and strong interest, and national support.

Old fashioned education cannot ready future citizens to cope with the problems of these latter decades of the 20th century. A strong democracy needs mentally and physically healthy individuals.

Passage of the Comprehensive Health Education Bill will do much towards providing youngsters a chance to acquire and use skills of decision-making about their health which will help lead them to a high level of well being individually and collectively.

EXHIBIT "A"

A K–12 HEALTH EDUCATION PLAN FOR WASHINGTON STATE SCHOOLS

(By Frank B. Brouillet, State Superintendent of Public Instruction)

PREFACE

This document is the result of hours of work by many Washington State educators, aided by national experts. It is the first major effort published which contains specific direction to local school district educators, parents, and students as to how they can begin to design, implement, and/or improve programs

to provide students with the opportunity to become engaged in processes which will enable them to fulfill many of the educational goals adopted by the Washington State Board of Education in January, 1972. It is a long-range plan and should be reviewed and revised periodically.

The stimulus for this effort was the recent drug crisis. Throughout the nation, educators have been struggling to develop effective drug education programs. As early as 1966, the Washington State Office of Public Instruction was advocating that drug education and other educational programs concerned with social health problems should be part of a total school health program. Although extensive efforts in drug programming have been produced during the past four years, they have been under the prevailing philosophy of health education. One should review the taxonomy located in the last portion of this document to insure an understanding of the scope of health education. "Health Education and the State Goals" is the first attempt to clearly relate health education to the encompassing "Goals for Washington Common Schools."

The major emphasis of this plan is on health instruction personnel and programs. Future efforts should focus more directly on school health services and other program areas.

I. PURPOSE OF THIS DOCUMENT

This document identifies a direct relationship between school health education programs and the educational goals adopted by the Washington State Board of Education.

This document provides a framework within the broad educational goals for persons interested in implementing and improving school health education programs.

This document provides direction, consonant with state philosophy, for educators, parents, and students who are concerned with the current low status of health education programs in Washington's schools.

This document provides specific recommendations for improving health education programs to educational decision makers.

This document provides the basis for cooperative health education program planning by educational groups, public, private, and voluntary health workers, students and concerned citizens.

The purpose of this document is to catalyze process.

II. GOALS FOR THE WASHINGTON COMMON SCHOOLS

In 1972 the State Board of Education formally adopted goals for the public schools in Washington State. This adoption came only after input was received from a wide and varied segment of Washington citizens.

The document identifies desirable outcomes of education as follows:

As a result of the process of education, each student should: Have the basic skills and knowledge necessary to seek information, to present ideas, to listen to and interact with others, and to use judgment and imagination in perceiving and resolving problems; understand the elements of his physical and emotional well-being; know the basic principles of the American democratic heritage; appreciate the wonders of the natural world, man's achievements and failures, his dreams, and his capabilities; clarify his basic values and develop a commitment to act upon these values within the framework of his rights and responsibilities as a participant in the democratic process; interact with people of different cultures, races, generations, and life styles with significant rapport; participate in social, political, economic, and family activities with the confidence that his actions make a difference; be prepared for his next career step; use leisure time in positive and satisfying ways; and be committed to life-long learning and personal growth.

III. HEALTH DEFINITIONS

Health is a state of physical, mental and social well-being, not merely the absence of disease. It is more than being well; it is having the energy and enthusiasm for life's activities. It is having a good attitude about oneself and others. It is accepting the fact that life has problems but that one works toward the solution or modification of these problems. Health is not an end in itself; it is a quality through which goals and dreams may be achieved.

Health Education is a process with intellectual, psychological, and social dimensions relating to activities which increase the abilities of people to make

informed decisions affecting their personal, family, and community well-being. This process, based on scientific principles, facilitates learning and behavioral change in both health personnel and consumers, including children and youth.

A Health Education Program is a planned and organized series of health education activities or procedures implemented with: 1) appropriately prepared personnel assigned primary responsibility; 2) a budget; 3) an integrated set of objectives sufficiently detailed to allow evaluation; and 4) administrative support.

School Health Education is that health education process associated with health activities planned and conducted under the supervision of school personnel with involvement of appropriate community health personnel and utilization of appropriate community resources.

IV. HEALTH EDUCATION SUBGOALS AND MAJOR RECOMMENDATIONS

Subgoal: Health Education can contribute to, and enhance the attainment of, the educational goals adopted by the Washington State Board of Education when competent health education personnel are available and employed at all teaching and administrative levels.

Objective 1

Assure that health education competencies are a part of the certification program for all educators.

(a) Develop health education competency specifications and evaluate criteria for all levels of teaching and administration.

(b) Develop advanced health education competency specifications and evaluative criteria for those individuals who will provide leadership in health teaching and/or administrative roles.

(c) Develop protocols for administering the certification program.

(d) Obtain the necessary official sanctions for implementing the program.

Objective 2

Upgrade the competency to a minimum acceptable level for all elementary and secondary teachers responsible for classroom health instruction.

(a) Conduct inservice training and/or continuing education programs for elementary and secondary personnel which will lead to appropriate recognition of achievement.

(b) Assure employment of appropriately prepared leadership in health education in all I.S.D.s and 1st class school districts.

(c) Assure that all elementary schools have identified at least one appropriately prepared teacher to provide leadership in health education at the building level.

Objective 3

Assess and evaluate the formal teacher preparation programs in health education in the State of Washington.

(a) Obtain the necessary commitment and support of the institutions of higher education to participate in this activity.

(b) Formulate the evaluation research design specifications (i.e., scope, criteria measure, methodology, etc.) for the conduct of the study.

(c) Retain qualified out-of-state consultants (to assure increased objectivity) to conduct the on-site evaluation-assessment study, and to prepare a report of findings, conclusions, and recommendations.

Objective 4

Assure that an adequate supply of prospective health education personnel (teachers and administrators) are available for employment by local school districts (and I.S.D.s).

(a) Prepare a four-year forecast (updated annually) of anticipated demand for health education personnel in the public schools of Washington.

(b) Develop and maintain a statewide health education manpower registry of "clearinghouse" to assist local school districts seeking qualified personnel.

(c) Maintain active communication with teacher preparation institutions of higher education, both in-state and out-of-state, regarding employment opportunities for qualified health educators.

Subgoal: Health Education can contribute to, and enhance the attainment of the educational goals adopted by the Washington State Board of Education when appropriate research findings and conclusions are applied to improving the quality of health education in the schools.

Objective 1

Encourage and promote the conduct of research (particularly, applied research) in health education and related fields by the faculty and/or students of the institutions of higher education in Washington.

(a) Identify and define important research needs as perceived by health educators.

(b) Communicate those perceived needs to the faculties of the institutions of higher education.

(c) Assist and support the institutions of higher education in obtaining funds for the conduct of research.

(d) Initiate at least one major longitudinal study in health education.

Objective 2

Establish a research "clearinghouse" for the collection and dissemination of research findings pertinent to the needs of health educators (teachers and administrators).

(a) Seek out a department of health education at one of the institutions of higher education that will assure this function.

(b) Design a system for collection, abstraction, and dissemination of research information.

(c) Develop appropriate arrangements for funding of the research clearinghouse program.

Subgoal: Health Education can contribute to, and enhance the attainment of the educational goals adopted by the Washington State Board of Education when the development of an increased awareness among citizens stimulates individual communities to assume their responsibility to provide a comprehensive program of health education that will assist young people in developing positive healthful behavior.

Objective 1

Obtain active citizen participation in, and support for, the continued development and upgrading of health education in the schools of Washington.

(a) Organize local citizen groups at the community level (school district or I.S.D.) to assist and advise local school personnel in matters pertaining to school health education.

(b) Organize a statewide committee (or a coalition of local citizen groups) to assist and advise personnel of the Office of the Superintendent of Public Instruction in matters pertaining to school health education.

Objective 2

Increase the public knowledge of what constitutes a comprehensive school health education program, the need for such a program, and the potential benefits to be gained from the program.

(a) Seek opportunities to speak before civic and professional organizations at the state and local levels.

(b) Develop and maintain a speakers file, publicize the availability of speakers, and assist interested organizations in obtaining speakers.

(c) Encourage and promote special projects or programs (i.e., "health fairs," parent-student projects, etc.) that create interest in and provide visibility for school health education activities.

Subgoal: Health Education can contribute to, and enhance the attainment of, the educational goals adopted by the Washington State Board of Education when *continuous* evaluation of health education programs is assured at all levels—classroom, school, district, I.S.D., and state—to provide feedback which will serve as a foundation for the improvement of school health education.

Objective 1

Development of a clear statement of the objectives of the health education program at each level (school, district, I.S.D., and state).

(a) Assess the characteristics of the school(s) and the community(ies).

(b) Develop the philosophy and objectives of the health education programs.

(c) Obtain the endorsement of the health education philosophy and objectives from the appropriate governing board.

Objective 2

Establish an ongoing committee responsible to the administrator for the continual evaluation of school health education at each level.

(a) Appoint a committee with representation from the faculty, community, and students charged with the task of evaluation.

(b) Develop a system for disseminating results of evaluation and a process to facilitate program improvement.

Objective 3

Implement a plan for continual evaluation of health education at each level—school, district, I.S.D., and state.

(a) Submit a plan for the implementation of regularly scheduled evaluation of health education input components (curriculum, teacher competencies, and course formats).

(b) Submit a plan for the implementation of regularly scheduled evaluation of health education outcomes through longitudinal measurements of student knowledge, attitudes, and behavior.

(c) Adopt, adapt or create a comprehensive self-evaluation instrument for health education input components.

(d) Adopt, adapt or create a comprehensive self-evaluation instrument for health education outcome components.

(e) Submit periodic reports of findings to the appropriate authority with recommendations for change.

(f) Plan and implement the recommended changes within a designated time frame.

(g) Create a system for sharing this evaluation information.

Subgoal: Health Education can contribute to, and enhance the attainment of, the educational goals adopted by the Washington State Board of Education when an equal health education opportunity is assured for all students, including special and minority groups, by recognizing and meeting individual needs.

Objective 1

Implement a baseline research project as a means of identifying knowledge, attitudes, and behavior which might be of value in assessing the health education needs of special groups with a district. (There may be groups of individuals who do not progress satisfactorily toward the health education objectives established by the schools; therefore, it becomes necessary to identify these students and determine if there are overriding factors, such as ethnic differences or handicapping conditions, which must be addressed by the schools to assure more effective health education for all students.)

(a) Implement a health needs assessment research project in each district.

(b) Identify social and health indicators as a means of needs assessment.

(c) Establish communication with local, state, and federal agencies to assist in the identification of student needs and for representatives of some of these agencies to serve in an advisory capacity to the school district.

(d) Determine if groups of students have similar needs which are significantly different from those of the population.

(e) Ascertain the impact which these needs have on education, the community, and the well-being of the identified groups.

(f) Evaluate the common characteristics of each group and those demographic traits which make it different from the majority.

(g) Prioritize the needs of the identified group(s).

Objective 2

Appoint a broad-based district advisory task force to render a report in the form of an action plan for meeting the health education needs of all students with particular attention to the problems and needs of identifiable groups within the district.

(a) Further evaluation of the needs assessment process to determine its validity and completeness.

(b) Determine whether the needs of the special group(s) require the addition of curricular areas or changes in curricular emphasis.

(c) Determine whether the needs of the special group(s) can best be met by pedagogical changes.

(d) Recommend to the district health coordinator the components of a health education program to meet the needs of the identified group(s).

(e) Identify additional community resources to enhance effective program implementation.

(f) Assess the components of the action plan in terms of personnel, resources, teaching aids, facilities, and equipment required.

(g) Present and explain the program to the community.

Objective 3

Create and implementation a plan of action through the institutions of higher education to recruit and prepare minorities in health education and to create a cross-cultural health education curriculum for the preparation of all health educators.

(a) An assessment of teacher training capabilities of Washington colleges and universities and institutions in neighboring states.

(b) Publication of a manpower report detailing supply, needs, and projections.

(c) Obtain from all colleges and universities an evaluation and report of the numbers of minority students presently being prepared in health education.

(d) Obtain from all colleges and universities an evaluation and report of the health education competencies presently being required of prospective special education teachers.

(e) Obtain from all school districts a report of the numbers and location of ethnic and racial minorities and special education teachers presently involved in health education.

(f) An evaluation and report of the existing cross-cultural health education teacher preparation programs in Washington and neighboring states.

(g) Provision of a statewide system for job placement for minorities.

(h) Provision of financial assistance for minorities desiring to enter health education teacher preparation programs.

(i) Provision of student teacher practicum placements in schools with significant numbers of minorities for students desiring to teach special groups.

(j) Periodic evaluation at two-year intervals of teacher preparation programs with regard to the preparation of teachers of special groups.

Objective 4

Create continuing education programs directed toward preparing teachers to teach health education concepts effectively to special groups.

(a) Utilization of local, state, and national agencies and groups to provide inservice experiences for all health educators.

(b) Inservice experiences which are practical and "real" are to be encouraged and supported by SPI.

(c) Inservice experiences must also focus on the development of effective teaching-learning materials for use with special groups.

(d) Continual evaluation of the effectiveness of the inservice experiences to serve as the basis for revisions.

Subgoal: Health Education can contribute to, and enhance the attainment of, the educational goals adopted by the Washington State Board of Education when the availability and accessibility of a variety of teaching media which facilitate the productivity of the health education process is assured.

Objective 1

Develop a network of regional health media centers through the I.S.D. offices.

(a) Provide a system through the I.S.D. to ensure equitable availability of media.

(b) Establish central resource centers for more equitable availability of media through the I.S.D. with supplementary centers at each district and building.

(c) Catalog available media resources available from public health agencies, voluntary health agencies, commercial distributors, and professional organizations.

(d) Create a centralized catalog or file of available teaching-learning media through SPI and the I.S.D. offices.

(e) Involve media specialists at the SPI and I.S.D. offices.

(f) Utilize available resources such as colleges, universities, commercial television stations, and local newspapers to a greater degree.

Objective 2

Appoint committees of health educators, allied professionals, and students to evaluate teaching-learning media.

(a) Appoint interdistrict committees through the I.S.D. for the evaluation and recommendations of teaching-learning media.

(b) Appoint interdistrict committees for the evaluation and recommendations of teaching-learning media.

(c) Catalog and evaluate commercially produced teaching-learning media.

(d) Catalog and evaluate materials distributed by voluntary and nonprofit health agencies.

(e) Use commercial media such as television, radio, and newspapers.

Objective 3

Initiate inservice education programs pertaining to the creation, use, and evaluation of media in health education.

(a) Provide inservice training for health educators through the I.S.D. offices concerning the types, use, creation, and evaluation of teaching-learning media, including the effective use of audiovisual equipment and computers as learning tools.

(b) Provide contact with community agencies and organizations capable of providing resources for school health education.

(c) Arrange for inservice training that promotes awareness of the resources of community agencies for school health education.

HEALTH EDUCATION TAXONOMY

This taxonomy provides the reader with an outline of the topics to be covered in a comprehensive health instruction program. Local effort and priority will be necessary to implement such curricular offerings.

The taxonomy should be considered in context with the definitions and recommendations contained in this plan.

1.0 Mental Health
- 1.1 Definition of mental health
- 1.2 Relationship to physical health
- 1.3 Relationship to community health
- 1.4 Determinants of mental health
  - 1.41 Physiological determinants—physical and hereditary
  - 1.42 Environmental determinants—physical and societal
  - 1.43 Psychological determinants
    - 1.431 Concept of self and others
    - 1.432 Psychological needs and motivation
    - 1.433 Sources and expression of emotions
    - 1.434 Outlook on life and values
- 1.5 Behavior influenced by mental health
  - 1.51 Communicating
  - 1.52 Decision making
  - 1.53 Risk taking—positive or negative
  - 1.54 Behaving responsibly or irresponsibly
  - 1.55 Suicide
  - 1.56 Adjusting—Adopting
  - 1.57 Problem solving
- 1.6 Values
  - 1.61 What values are
  - 1.62 How values are acquired
  - 1.63 Importance of specific values to mental health
    - 1.631 Self discipline
    - 1.632 Self respect [illegible] ceptance
    - 1.633 Respect fo[illegible] eptance of others
  - 1.64 How values influence decision making
- 1.7 Applying a value system to problems of daily living
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    - 1.732 Nature of drugs
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- 2.4 Growth and development and individual differences
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  - 2.42 Cell
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TASK FORCE HEALTH/DRUG EDUCATION, FEBRUARY–MARCH, JUNE, 1973

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Lillian Cady, Associate for Teacher Education, SPI.
Herb Campbell, Administrator, Richland School District.
JoEllen Clees, Student, University of Washington.
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Kenneth Coon, Teacher, Mead School District (Spokane).
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Robert Davidson, Teacher, Bellevue School District.
Lorraine Davis, Health Education Department, University of Oregon, Eugene.
Shaunne Doxie, Student Evergreen High, Highline School District (Seattle).
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Mark Falk, Student Mead High School, Spokane.
Douglas Goodlett, Teacher, Tacoma School District.
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Nancy Guthrie, Teacher Training, University of Puget Sound, Tacoma.
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Eleanor Hogan, Supervisor Nursing Services, Highline School District, Seattle.
Michael Hosokawa, Associate Professor, Health Education, University of Oregon, Eugene.
Doreen Johnson, Teacher, Federal Way School District.
Keith Johnson, Teacher, Cape Flattery School District, Neah Bay.
Harry Johnson, Research Association, SPI.
Gene Liddell, Teacher, Olympia School District.
Pam McGee, Teacher, Tacoma School District.
Lawrence Merline, Coordinator Health and PE, Federal Way School District.
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Stephen Oliver, Teacher, Tacoma School District.
Lorraine Owen, Teacher, Evergreen School District, Vancouver.
Manuel Padilla, Consultant Migrant Education, SPI (Kittitas).
Marshall Pancheau, Teacher, Bellevue School District.
William Parker, Counselor, Wapato School District.
William Pinnick, Elementary Principal, Bellevue School District.
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Ralph Rideout, Director State Interagency Committee, Drug Abuse Prevention.
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Jean Workman, Supervisor Health Services, Spokane School District.

Ms. TRUCANO. I am at present assistant in health education for the Seattle Public Schools which has 115 schools. Prior to that, I was supervisor of health education in the State office of public instruction. Prior to that, I have spent 25 years in public schools in the State of Washington.

I would like to summarize only briefly the written testimony that was presented because much of what I would have said was said yesterday in the hearings, but I would like to elaborate on a couple of points that came up yesterday that would relate to the written testimony.

Yesterday there was an indication that the Administration felt that the job of health education was already being done. Two extensive studies indicate that it is not. One of these studies, the school health education study, was done, of course, 10 years ago, but things have not changed that much, and the report of the President's Committee on Health Education was done very recently.

Furthermore, I am not aware of any study that has been done that indicates that it is being done, and in my 25 years of public school experience I have yet to see a school district with a full program of health education, in the State of Washington or elsewhere.

I have seen some excellent elementary health education teachers teaching health. I have seen excellent health courses being taught at the secondary level, but I have not seen a full program, and I believe I have visited almost every school district in the State of Washington and many outside the State.

The U.S. Office of Education, in a report prepared for the President's committee, could cite no single program of research or evaluation in supporting the area of school health education.

Categorical funds have begun to help develop and implement components of comprehensive health education, but most of these programs are initiated and then deserted when funds no longer are

available because there is no viable framework in which to hang the categorical programs.

Some people may feel that health education program is being done because of lack of understanding of what a program really is.

Let me try to begin to give you an example of a good fifth-grade program. Students study all the body systems. They have a plastic torso which they can take apart and put together, and they have earphones, listening to tapes to tell them about the body systems.

They select the respiratory system for intensive study, and they dissect lungs. It is an experience to watch fifth-grade youngsters dissect lungs, to watch their faces as they begin to understand what the lungs look like and how the lungs work.

Then they experiment to find out how smoking affects the lungs. Then they do some experiments to find out how air pollution affects the lungs. Then they discuss how—what kinds of things prevent air from getting into the lungs, such as drowning, so water safely becomes a factor. Then they practice mouth-to-mouth resuscitation.

Then they discuss maybe what drugs might inhibit the breathing, so they get into drug education. Then they discuss decisions and how they are made. How do your friends and advertising and feelings of inadequacy affect the decisions you make in life?

Thus, the study of the respiratory system takes on more meaning to them.

This description is really just a part of what ought to be done at the fifth grade level, and yet some people never get even a part of this in 12 years of schooling.

These same fifth grade youngsters should have a chance for this learning in later grades. If reinforcement isn't necessary, then why do we insist that students have math and English and science for 10 years?

Someone yesterday mentioned that smoking education and sex education have not been successful. I agree, but would English or biology or math be successful if we gave them only 1 year or 1 week in 12 years of their schooling?

The joint committee of the National School Board Association and the American Association of School Administrators stated that there was neither time nor justification for separate courses in 30 categorical areas of health. They felt that a long-range program on topics carefully tied to students' needs and interests and integrated would receive more complete consideration at the time when youngsters were intereted in those areas.

I feel that the Comprehensive Health Education Act can provide the means for the development of a curriculum framework which will remain after initial funds no longer are available.

In the case of the elementary program that I just spoke of, it would be incumbent upon the health educator of those districts that have such programs to incorporate them into a total program.

When and where excellent components of a program already exist, such as nutrition and family life and home economics, the health educator should coordinate with home economics people and not duplicate what already is occurring, but in home economics there may be need to extend what they do because it does not reach all students, and, furthermore, home economics is not taught in the elementary

grades, and beginning concepts of nutrition and family life need to be begun earlier than in the secondary grades.

It is, therefore, imperative that someone do the designing and the coordinating of this mosaic program so that no pieces are missing. It is obvious that pieces are missing as we look out at our young people and we find some mental health problems.

We find the beginnings of alcoholism. We find epidemics of venereal disease. We find high incidence of accidents and on and on and on, indicating to us that there are some pieces missing.

The Comprehensive Health Education Act would give us the opportunity to design educationally complete programs that would not duplicate or throw out that which is good and that which already exists.

It is reassuring to note that the author and sponsors of this bill have seen fit to include a prominent role for State educational agencies. It should be recognized that many State educational agencies are already giving leadership in health education.

For example, in Washington State we have supported a full-time supervisor in health education since 1966. In addition, this year we are utilizing title V, ESEA funds to support an administrative skill training program in health education and develop a model junior high program in one of our local districts.

There are two concerns that we have about the administration of this bill even at this early stage. One is that adequate safeguards be established to insure that the intent of Congress is followed in the administration of this bill.

We do not want it to be all things to all people. We would want very much that health education be given a chance.

The second concern is that State educational agencies should have an input to major policy and program decisions before finalization. We feel that well-laid plans should receive money, that plans should not be changed to receive the money.

Thank you.

Acting Chairman MEEDS. Thank you very much, Lucille. Congressman Perkins?

Chairman PERKINS. I just want to compliment the witness for her most excellent testimony. I doubt that we will have a better qualified witness come before this committee. I do have a question.

Do you have any evidence that a comprehensive health education program would work? Everyone seems to agree that single, one-time courses on drug abuse and so forth don't work. Just what evidence do you have that this program would work?

Ms. TRUCANO. We really don't have any evidence because we don't have a comprehensive program. We have never had one to evaluate, and that is one of the real needs, a longitudinal study to evaluate the effects.

I think we base our feeling on the fact that we believe in education, and, if education makes a difference, we believe health education must make a difference.

The component program such as drug education is found lacking because such programs isolate themselves from total living, and we see health as really total living. Drug education—the problem of drug abuse is not drugs. The problem of drug abuse is people.

70-980—76——6

Chairman PERKINS. Those are single programs and many people feel they haven't worked, but maybe I didn't get my point across. Since you feel that we should move to a more comprehensive approach——

Ms. TRUCANO. For instance, in drug education you have to get into the motivations for drug abuse. You have to get into societal influences on drugs.

Chairman PERKINS. It would be much better if you had moved in the direction of a comprehensive approach?

Ms. TRUCANO. Right, because you touch on all those things.

Chairman PERKINS. Thank you very much.

Acting Chairman MEEDS. Thank you, Mr. Chairman. You are asking questions along the very line I am concerned about.

Could you just give us as a very general concept what you consider to be a comprehensive health education program, Lucille? When it begins, when it ends; what are some of the subject matters; how things are taught.

Ms. TRUCANO. It begins in kindergarten. It begins in the home, of course, but in the schools it would begin in the kindergarten, and from kindergarten through 12th grade you would have a thread of what we call mental health, and that means understanding self, realizing that you are a unique individual and yet you are like all others, realizing the kinds of things that impinge upon you to make you feel good or not, things that influence your decisions.

Then we get into what we call our traditional health packet such as anatomy, physiology, starting early so that young people can begin to appreciate the human body. In early grades, they find a great excitement in the study of that, getting into the kinds of things that can harm the human body, substances, accidents that might harm them; getting into the things that help the human body, exercise, nutrition, balanced activities, moderation.

We do not say that you need to repeat these things every year. In other words, it might be—for instance, the human body being fairly heavily studied in fifth grade, and it may not be studied again until eighth grade. Then in high school, for instance, if students wanted to understand fetal circulation, they would review the circulatory system, but not really study it as such.

We see a need in elementary grades for it to be all tied together, but at the secondary level we see a need for actual time in the curriculum where you focus in on it, where you have qualified teachers, where you have enough learning materials that kids can be involved in active learning.

I think that this is a real key that kids learn in different ways, and we must have all kinds of materials and all kinds of levels for them.

Acting Chairman MEEDS. Let us take the subject of teaching health education. Do you think that the average elementary teacher today is prepared to teach the types of things you are talking about, at the early levels, fifth grade for instance, physiology?

Ms. TRUCANO. We have found that many of them do not have the knowledge. We can provide that with inservice and we have done this in the State of Washington where we have coordinated up and

down the Puget Sound area, all of us working together to put on inservice programs.

We can give teachers the knowledge in a very short time. They have the methodology, so that part is not too hard. They need two things in inservice. They need some knowledge because they themselves have not had a good K–12 program, and then they go on to teacher preparation and they don't get any, so we do need to give them background and knowledge.

Then we need to give them this concept of health rather than illness. We do know ways. We do have enough knowledge, if we had the desire, to make decisions that could make us function at a high level of well-being.

Acting Chairman MEEDS. Let us take the subject of drug abuse. Could you follow through—well, first I should ask you this. Do you feel drug abuse is part of health education?

Ms. TRUCANO. Yes. Drug education.

Acting Chairman MEEDS. I knew you did, but I wanted that on the record. Could you follow through, just give us a thumbnail sketch of how you feel drug abuse fits into health education, how it should be taught, when it should be started, and so on?

Ms. TRUCANO. In the primary grades, we should help young people like themselves. People wonder what that has to do with drug abuse, but later on then they don't need to drop out of society by abusing it, so we start out with: "You are great. You are different and you are great."

We talk about things such as: If you are ill, who do you go to? The nurse? The parents? We talk about not taking any medicine without your parents' permission, that kind of thing.

Then at the intermediate grade levels, you get into studying the human body, so they begin to appreciate the real miraculous kind of mechanism that we have, that we function with, and we talk about here again the values of drugs, that we have a longer life span because drugs have been effective, but we also talk about what kinds of things can harm the human body and then we get into drug abuse among other things.

Then I think in junior high they need to begin to look at how people influence them, their peers especially. Why do you feel that you need to be a part of the group? If your group begins to smoke pot and you don't want to, what does that do to you? You pay a price if you do and you pay a price if you don't, and kids ought to be able to see that and try to see what their alternatives are.

I think another area of junior high should be: How do you get high on life without drugs?

Then in senior high we would like to get more into: How will you as a parent help your children feel that they are loved, feel that they are secure, so that we won't have a repetition of drug abuse?

We also should get into how drugs affect the fetal and the embryonic development, so drug abuse for us branches into all kinds of directions rather than: Should you use heroin? Or: How does heroin affect you? That is part of it, but that is a very minor part of the total needs.

Acting Chairman MEEDS. One of the, I think, justifiable complaints about some of the drug abuse education programs has been that they are informational only.

Ms. TRUCANO. Right.

Acting Chairman MEEDS. And that they are counterproductive. I don't envision the kind of program you just talked about as being informational only. It is obviously very much more in depth educational process with regard to the use or abuse of drugs, and I think this is the kind of thing that we are really talking about when we talk about health education being comprehensive and starting at a very early age and continuing with the evaluation of a lot of things, not just a substance.

Ms. TRUCANO. It is a longer, costlier, more complex—it is like English. They teach it 12 years, but it is reinforced in other classes.

Acting Chairman MEEDS. Do you feel that health education—the kind of health education program that you are talking about ought to be mandatory?

Ms. TRUCANO. I do, only because other subjects are. We would like to—we feel we could fare very well if all subjects were elective, but when—It is an unfair race when you put us 50 yards behind by giving us an elective status with the other subjects required.

Acting Chairman MEEDS. You feel health education is as important to the individual and to society as mathematics, English, some of the other things that are mandatory in most schools, Washington State history, for instance?

Ms. TRUCANO. Yes, I do. I feel that it is a basic subject although it is not considered that by educators, but I can see nothing that is more basic, and from the time educational objectives have been stated, we have had an objective for health, but we have never fulfilled that objective.

Yes, I do. I feel it is as basic reading and math.

Acting Chairman MEEDS. Chris, do you have any questions?

Mr. CROSS. I am curious as to what priority you would put for this bill as against, say, funds for the handicapped or funds for compensatory education. Where would you put health education in a list of priorities?

Ms. TRUCANO. That is a really tough one.

Acting Chairman MEEDS. That is why he is Republican counsel.

Ms. TRUCANO. I feel that, for instance, the handicapped need this as much as the so-called nonhandicapped youngsters. Furthermore, I see in health education opportunity to help the so-called nonhandicapped. The reason I say "so-called" is that I think we all are handicapped in ways.

I think that we need to understand what those people are going through, their feelings, and be able to understand their assets. I feel that is one of our great needs, that we do not have health programs for, say, the visually impaired or those with hearing handicaps, or those who are retarded.

We really need health education designed especially for them.

Mr. CROSS. I would suspect that it is a question of there not being enough money to do everything and therefore one has to pick and choose which is most important.

Ms. TRUCANO. Right. We are talking about priorities really. That is where we are at.

Mr. Cross. You mentioned that you didn't think that programs such as these in drug abuse and other areas have been effective. Would you think that, if this new act were implemented, those other programs should be terminated?

Ms. Trucano. Not really terminated. I think two things happen. One, they are incorporated; and, two, they are modified.

Drug abuse education, as I saw it for the last five years, was information-giving, and in a sense I think it made kids curious and increased the normal experimentation found in young people.

I don't see it eliminated. I see it modified and incorporated.

Mr. Cross. I had reference specifically to the Federal laws on drug abuse and environmental education, nutrition education, and things of that sort. It seems to me that you need do something to bring those together. To allow them to continue to operate and then to bring in a new law to preempt the field might create great confusion.

You would have the comprehensive approach on one side and then you would have the single shot programs going alongside them, and it doesn't seem to me that this would be effective.

Ms. Trucano. I would not want those people to be angry with me, but yes, I do see that they should be under one umbrella because teachers will—That is one thing teachers will say to you, that: "Gee, we have got so many things now. Don't give us another thing."

But if you could help them see that these things are interwoven, then it isn't another thing, so for elementary teachers especially it becomes a part of many other things

Mr. Cross. Do you think there is a need for a long-range Federal role in this area or is it more one of stimulating the field and getting the States to commit their own resources and communities to understand the problem? Do you think it is something that after 5 years or so the Federal Government could back out of, assuming that states have taken on some role?

Ms. Trucano. I feel very strongly if you have trained leadership that in 5 years—and sufficient money to develop your programs, I feel that we could, looking at the State of Washington—that we could then go on our own.

Once we have the designing and developing of a program—that is a very costly, time-consuming kind of thing, but, once that is done and once you have leadership to carry it on, I think we could do it without really any extra money.

I say that because in 6 years in the State office, I would go into a district and they really did want to improve their program, but I could not stay there and there wasn't trained leadership to carry on what we might have done in a week, you see, so all that was lost.

I really believe that most districts want to do something, but we first have to—and your bill does this—train some leadership.

Mr. Cross. It seems to me that training is very important. One just can't go into this without having qualified people to handle it. Are you aware of the several bills for national health insurance? I suppose there are 20 or 30 of them in the hopper now. Many of them call for and would require health education as a component of a national health insurance program. This is not so much in the

way of a question to you, but I do think we need to think about relating that to this legislation as well.

There are a number of laws, the health and maintenance organization law for instance, that require patient education. At some point you may potentially reach overkill on the subject from the various viewpoints of various programs which are not related.

Certainly, if national health insurance becomes operative with an education component you would be reaching virtually everyone in the country, so I think that the problem has to be considered.

Ms. TRUCANO. As I see the educational component of national health insurance, it occurs to me that when a person is in need of some health care, that is when—for instance, you go in and you get some pills from your doctor and he tells you how to use them, but because you are so upset with what you have, you don't hear him, and then, of course, the education is coming back later when you are receptive. I think that is a different kind of thing. It is more immediate. It is more illness oriented than what we—we are talking about trying to function at a high level of well-being.

Like today. We are here. I don't know how healthy we are. Some of us might have aches or ulcers or whatever and we are not at that level that I think we are able to function at most of the time, so I see it as a little different.

Mr. CROSS. I am not familiar with all of the health laws and proposals, but I think some of them do envision it as preventive education, not just after the fact education programs.

Well, thank you, Mr. Chairman.

Acting Chairman MEEDS. Thank you very much, Lucille, for some excellent testimony.

Ms. TRUCANO. Thank you.

Acting Chairman MEEDS. Our next witness is Mr. Willard McGuire, who is vice president of the National Education Association.

In introducing and presenting to the committee—subcommittee, Mr. McGuire, I would like to express my personal thanks to the NEA for its utilization of its own resource people to help in the drafting work with this. We have been particularly helped by Carl Troester of NEA, AAHPER, and by other people in your organization, Mr. McGuire, and we greatly appreciate your support for this legislation, and we are looking forward to your testimony.

Mr. MCGUIRE. Thank you.

STATEMENT OF WILLARD McGUIRE, VICE PRESIDENT, NATIONAL EDUCATION ASSOCIATION

Mr. MCGUIRE. Chairman Meeds and members of the subcommittee, my name is Willard McGuire and I am vice president of the National Education Association of the United States.

The NEA is an independent organization to all professional educators. It has over 1,600,000 members employed in the public schools and is the largest organization of public employees in the nation.

The National Education Association has an affiliate in every State and has over 9,000 local affiliates. When we include these organizations, the NEA speaks for a combined membership of almost 2 million public employees.

I want to take this opportunity to thank you for extending an invitation to testify on the Comprehensive School Health Education Act. The National Education Association has affirmed in its resolutions its recognition that the total environment, including home, school, and community, affects the mental, emotional, and physical health of children.

The NEA representative assembly in each year since 1969 has voiced its commitment to providing comprehensive school and community health facilities and Federal health plans to meet the needs of children.

This country is by far the technological leader of the world, but we have health problems that are totally unjustifiable. Our society has grown more complex with every subsequent mechanical and scientific achievement, and at the same time more impersonal.

The incredibly high incidence of such maladies as heart disease, cancer, mental illness, malnutrition, air, water, and land pollution, venereal disease, and drug abuse are far out of proportion to our potential resources to deal effectively and completely with these problems.

The recently published Report of the President's Committee on Health Education found that most of the 59 million children enrolled in elementary and secondary schools have no opportunity to participate in comprehensive school health education programs.

For them, health education either is not provided at all or is fragmented, lacking in planning, scope, sequence, and evaluation, and in commitments of time, money, administrative support, and legal sanction.

Among the several recommendations of the President's Committee on Health Education were:

First: That adoption of model State laws for school health education be encouraged in every State, covering the programs themselves, teacher preparation, reporting, and evaluation of results;

That periodic surveys determine the health education needs and interests of students from preschool through college, for use in planning and developing health education programs;

That the Department of Health, Education, and Welfare and/or its Office of Education be urged to initiate system of research and evaluation of projects in school health education.

The Meeds bill—H.R. 2599, 2600, and 2601—provides much needed support for State and local development of comprehensive school health education programs over a 3-year period.

The funding is through direct grants to State education agencies and higher education facilities of $37.5 million and $52.2 million in direct grants to State and local agencies for pilot and demonstration projects and curriculums.

The bill would also entitle local and State agencies of education to $50 million in grants for the development of comprehensive programs in elementary and secondary schools in health education and health problems.

As a classroom teacher for many years, I see value in several details of this that I would like to relate to as well. The fact that in all subject matter areas where new things have been tried and in some cases have failed, a couple of things have been lacking.

One, the proper research and piloting of materials to see which things truly do work and which are not effective and, probably more important yet, is the matter of inservice training, and a part of H.R. 2599 directs itself to both preservice and inservice training.

Unless we work with the teachers who are already in the field to help them, then a program is doomed to failure, and I think that is one of the strengths in this particular bill.

I know earlier questions referred to things that have failed in the past, and I think many of those failures can be attributed to the lack of inservice education.

I wish to say that NEA will support the Meeds bill and, upon enactment into law, its implementation through our affiliates and associated organizations as well as through coalitions to which we belong.

We recommend that professional educators enter into active collaboration with research and development specialists, both in regional educational laboratories and in industry, to promote technology's potential contribution to health education by guiding the development of pilot and demonstration projects and curriculums in the most educationally sound directions.

The National Education Association strongly recommends that the professionals, in cooperation with other interested groups such as public school nurses, establish standards for health education materials, and insist that publishers and producers use the services of a competent educational institution or facility to field test in actual classroom situations such materials and publish the results of their effectiveness.

NEA also recognizes the contributions of public school nurses and urges the school systems to effectively involve and utilize the wealth of resources the school nurses can share in their consultative postures to the health education process. The process should involve, among other activities, problem solving, workshops, seminars, demonstrations, and curriculum development.

NEA believes that health education that provides children and youth with information appropriate to their needs and interests is basic to a healthy being, mental, emotional, and physical. We, therefore, urge on behalf of the National Education Association that this committee report favorably H.R. 2500.

Acting Chairman MEEDS. Thank you very much, Mr. McGuire. I am particularly struck by your statement at the bottom of page 1 in which you say that the recently published report of the President's Committee on Health Education found that most of the 59 million children enrolled in elementary and secondary schools have no opportunity to participate in comprehensive school health education programs.

Are you aware, Mr. McGuire, that we have correspondence from the Secretary of HEW indicating that this bill, H.R. 2600, is not needed because it is covered by other legislation?

Mr. MCGUIRE. I am not aware of that correspondence, but I am not too surprised at it from the standpoint that I think generally across this land people believe that health education is going on, and a little later in the testimony I refer to fragmented—and the

previous witness spoke to that too, the one-shot kind of things in drug abuse and the rest.

So it is quite natural and I think probably rather universally believed that we do have health education. Most people can recall some sort of health education in their own educational experience, but I think, if they are honest about it, they would agree that it was fragmented, that it was not comprehensive, and in many cases did not have the desired outcome that we certainly are hopeful this bill would bring to us.

Acting Chairman MEEDS. So when the President's commission reported that these young people had no opportunity to participate in comprehensive health education programs, they knew what they were talking about.

Mr. MCGUIRE. I believe they did and it was probably that HEW missed the word "comprehensive" and listened most to health education, and I would have to agree that there is health education, but far from being comprehensive.

Acting Chairman MEEDS. I see. Now, I am glad that you recognize that this is a developmental bill. The money in this would not begin to take care of even a small portion of the total grants that would be needed to launch health education in this Nation, would it?

Mr. MCGUIRE. No, they would not.

Acting Chairman MEEDS. But the funds are, as you point out, for development of curriculum teacher training, inservice and preservice training, things like that. Very small, but adequate to get started, wouldn't you think?

Mr. MCGUIRE. Yes. I think the developmental program—that they would be adequate, and as things are successful, then—and I believe they will be with the kind of things that are written into the bill—then more money would be required to carry out an extensive program, but this could be asked for in terms of known successes and not in terms of the research area. Education in general is not in research funding.

Acting Chairman MEEDS. I am sure you would agree with me that it is not the intent of this bill or the sponsors or of NEA in supporting this legislation that these programs be forced on school districts. grams that are necessary to prove the effectiveness of comprehensive It is merely a matter of doing research and developing pilot programs that are necessary to prove effective comprehensive school health education programs and to make them available if individual school districts want them.

Mr. MCGUIRE. I think there are many school districts waiting for this kind of thing or other developmental programs, to buy into them and to field test them for us, and later, if they are exemplary, to follow through with them.

Acting Chairman MEEDS. Fine. Any questions, Chris?

Mr. CROSS. If I could, may I ask the question I did of the previous witness about priorities and where you would see this in a list of priorities for Federal funding?

Mr. MCGUIRE. Well, I find the priority question to be a very difficult one because I have a high priority and the National Education Association shares the high priority for human resource funding,

and that covers a rather broad range, and I would hate to prioritize in terms of the education for handicapped children and this sort of thing as against the other.

I would hope that the funding would be obtainable to take care of both. I think we have dire needs in special education and I think we have needs here, and it doesn't seem to me that the amount of money involved in either of these programs is excessive in the Federal budget and I think that both could be accomplished.

I really hate to put one over the other. I feel strongly about both.

Acting Chairman MEEDS. If I might interrupt, in terms of prioritizing, I assume you would consider this to be more important than an additional $300 million to South Vietnam?

Mr. MCGUIRE. Very much so. Yes, in that kind of prioritizing, but he was in the human resources where it would go one against the other I think we do have some good things going in terms of compensatory education for those who are handicapped and so on, and those need increased funding because the expenses of educating those children is greater than for the nonhandicapped, but we need this too to get to the masses who are lacking in comprehensive——

Mr. CROSS. As a teacher organization, do you have any feel for the number of people out there who are trained now to be able to do this? What is the gap? How many would really need to be trained to handle health education and how best can we train those people? Should we be training new people coming out? Should we be retraining? Should we be doing both?

Mr. MCGUIRE. I think retraining is more important. I have no idea as to the numbers needing it, except to say that in new programs over the last 15 or 20 years that have come out, it has been strongly evident that a lot of retraining was necessary in order to do the job.

I will use one example. Since health education isn't my field—I am a junior high mathematics teacher—I will give you new math as an example. New math comes in for its share of accolades and for strong criticism as well. One of the things that happened was that new math concepts should be involved from K through 12, and quite a bit of retraining and inservice was done with junior and senior high teachers, very little with elementary teachers, thinking that that could be accomplished by them on their own with their reading, and one of the very difficult things is that the elementary teacher has to be all things to all people, and they have such a heavy load and such a diverse set of things to teach that they needed the inservice training very much, maybe even more so than some others.

I think we would find in this case too that, as the previous witness said, it should be a K through 12 program, at least as far as elementary and secondary schools are concerned, and the already overloaded elementary teacher would need inservice training, some kind of retraining.

With fewer people coming into the profession today, I think we have to emphasize the retraining, inservice training which is the name we usually give to it, and we would not be able to give numbers at this time as an organization.

Mr. CROSS. At the elementary level then, you would see this operating as health education being one of the things that a typical class-

room teacher would handle, rather than as a specialist who would go around from room to room during periods of the day?

Mr. McGuire. It certainly could happen either way, but I think we have to realize that across the country there is no one pattern. In certain school districts, they have moved toward departmentalization and toward specialization, and in those areas they might want to use teachers in that manner, but what is referred to as a self-contained classroom where the teacher teaches almost everything with little outside help—that teacher would have to be given some inservice training in this regard.

Mr. Cross. Would you agree with the previous witness on the need to establish this as the Federal priority in health education and to terminate those other categorical programs?

Mr. McGuire. Yes. I really feel that they could be integrated into a comprehensive health program because there are numerous things that are being done on a one-shot basis that in my estimation are part of the overall comprehensive health education of children.

Mr. Cross. Thank you, Mr. Chairman.

Acting Chairman Meeds Thank you, Chris, and thank you very much, Mr. McGuire. We appreciate your testimony and your personal dedication and the help of your organization.

Mr. McGuire. Thank you, Chairman Meeds.

Acting Chairman Meeds. Our next witness is the Reverend Trafford P. Mahar, member, Board of Directors, American Social Health Association, St. Louis.

Come forward please.

Reverend Mahar. Thank you.

Acting Chairman Meeds. Please proceed.

STATEMENT OF REVEREND TRAFFORD P. MAHAR, MEMBER, BOARD OF DIRECTORS, AMERICAN SOCIAL HEALTH ASSOCIATION, ST. LOUIS, MO., ACCOMPANIED BY SAMUEL R. KNOX

Reverend Mahar. All right. Mr. Chairman and members of the subcommittee, I am Trafford P. Mahar, a Jesuit, director of the Human Relations Center for Training and Research at St. Louis University, St. Louis, Mo., and a member of the board of the American Social Health Association since 1954.

I am addressing you both as a professional educator and on behalf of the American Social Health Association. This association, founded in 1912, is a voluntary nonprofit agency, dedicated to the elimination of venereal disease as a major social health problem through a comprehensive program of research, information, education, and citizen action.

With me today on my left is Mr. Samuel R. Knox, venereal disease program director of the association, who is responsible for program development and implementation.

Mr. Chairman, my statement is brief and, if it would please the committee, I would welcome the opportunity to read it into the record. If the Chair wishes, I am prepared to submit it for the record and briefly summarize it prior to questioning.

Acting Chairman MEEDS. Whichever is more comfortable to you, sir.

Reverend MAHAR. All right. I will just read it. It is very brief.

Acting Chairman MEEDS It is short.

Reverend MAHAR. Venereal disease is a most serious problem in the United States today. It is a problem of staggering proportions: Nearly a million new cases of VD were reported to public health authorities last year, and according to the U.S. Public Health Service at least another million cases were treated but not reported.

It is also a problem of profound medical consequences. Untreated syphilis can lead to blindness, insanity, heart disease, paralysis, and death. Untreated gonorrhea can lead to sterility, gonococcal arthritis, endocarditis, septicemia, and even death. Both diseases have serious neonatal implications.

Venereologists cite that among the main causes of the high VD rate are the new lifestyles, increased mobility, changing concepts of morality, and fewer behavioral restraints.

VD prevention and control have frequently been hindered or stalemated by ignorance, misinformation, public apathy, lack of finances and manpower, and, perhaps most significantly, inadequate venereal disease education.

The uninformed individual is ill-equipped to take those prevention-oriented steps that will minimize his risk of exposure. Unless VD is detected in a routine physical examination, or as a result of the epidemiologic process, an individual must request a VD checkup in order to have the disease diagnosed.

However, only a person who is aware of the risks, who understands how the disease is transmitted, and who can recognize the early signs and symptoms is likely to seek such a checkup, which means that the person must have been educated to respond in this intelligent fashion.

It is at this point that I should like to affiliate ourselves very much with the bill that is being proposed because it is education that is going to be the greatest prevention in the area of this communal disease.

Education, therefore, is one of our best tools for VD prevention and control. Studies have indicated that the recipient of quality VD education possesses an enhanced ability to engage in health-seeking behavior. That is, to minimize his risk of exposure and to rapidly seek diagnosis should he suspect infection.

Far from being theoretical, the efficiency of quality venereal disease education was clearly demonstrated in a pilot program of the San Francisco Unified School District conducted between 1968 and 1972, which was stimulated by the American Social Health Association.

The VD attack rate among the 15- to 19-year-old age group was cut in half during those 4 years. The factor acknowledged as most significantly contributing to the reduction in the teenage VD rate was the pilot VD education program.

While children between the ages of 15 and 19 represent only 10 percent of our total population, they tragically account for nearly 30 percent of the reported venereal disease morbidity.

We have a compelling obligation to our Nation's schoolage youth to obliterate the ignorance and misinformation that for too long has permitted these dreaded diseases to flourish within their ranks.

We are obligated to provide accurate, constructive, and helpful information that will better enable these young people to enjoy healthier, more productive lives.

The act which you are considering represents a big step in the right direction. Encouraging the development of sound health habits in children through a comprehensive school health education program is absolutely essential.

Within that context, we anticipate that VD would receive the same accurate and unbiased treatment as would dental health, environmental health, nutrition, and the like.

I am convinced that this is a sound, reasonable, and effective means of influencing health habits, and by so doing, impacting on the national VD epidemic, and I would like to emphasize that we do have a VD epidemic.

I am, therefore, both personally and organizationally extremely supportive of this proposed legislation and urge its rapid enactment into law.

Thank you, Mr. Chairman.

Acting Chairman MEEDS. Thank you very much, Father. I see that you—and you have been working in this area specifically and mine is just a passing knowledge——

Reverend MAHAR. Longer than I like to admit.

Acting Chairman MEEDS [continuing]. From the health education standpoint, but I noticed in the President's Commission report a statement to the effect that in one Los Angeles high school that they examined one out of five students would have VD prior to graduation, and that in the same school district the teachers were not even allowed to mention VD in their teaching.

Is it any wonder that this type of situation exists under those circumstances? Why is that, Father? Is it the same problem that we confronted in drug abuse education? Some people think that to educate about something is to make it more susceptible to misuse?

Reverend MAHAR. I suspect there are a number of factors that are hidden here. Let me cite a study that the American Social Health Association did with the American Medical Association, in which the total universe was studied. That is to say, all the members of the American Medical Association and with a very high response rate of 75 percent.

What we learned there was that the closer the patient gets to my religious and socio-economic group, the less likely I am to report it as a physician. In other words, these awful things happen to those other awful people, but not to my group, so somehow or other I lose some of my self-enhancement if someone takes on something that has been taboo for so long in our society. I think that factor is there.

Then I think there is another factor there. Schools treat very noble things. This is not a noble thing. Therefore, it is not the business of the school. I believe that factor is there, that somehow or other it will seem that my school district condones certain things if I teach about it.

I am sure there are other factors there, but I cannot think of them at the moment. I will think of them on the way home. [Laughter.]

Acting Chairman MEEDS. Could you give us some idea how you feel that venereal disease education would be integrated in a comprehensive health education program?

Reverend MAHAR. Yes. It seems to me up to this point we have had many fine efforts in our pluralistic school systems across this country, private schools, public schools, many fine thrusts to address themselves to problems, but, as the previous persons giving testimony has so well said, these have been fragmentized. These have not always dealt with the motivational and attitudinal life of the students in the class. They gave them information. They gave them statistics. They talked about things.

I think, therefore, some of these things have not worked out too well. One of the things that appeals to me very much as a person coming out of the psychiatric field as well as obviously a clergyman, is that this treats the total human being in a total life context situation.

I think in terms of previous questions asked of other persons at this table that we need to do an awful lot of synthesizing of current programs, and I see this particular bill as maybe being a thrust in the right direction to form the hub of the wheel, and spokes going out from it might be other allied programs, but some kind of a unifying program.

Acting Chairman MEEDS. Do you know about--could you describe at all in any detail the San Francisco Unified School District program which you testified to?

Reverend MAHAR. First of all, that was part of a long series of programs that the American Social Health carried on in various parts of the United States, backed by a private foundation. This actually was an attempt to raise the level of wareness in that community at large about the problem, to get yon gsters talking about it in a way in which they felt comfortable, in which they saw the values that were involved, the aspects of human dignity, and so forth.

That primarily was the content and the trust. Perhaps Mr. Knox has something he would like to add.

Mr. KNOX. Well, specifically the way that operated—it was a comprehensive approach. It included more than just simply school education in venereal disease, and it was stimulated by the fact that that city's school-age population had a VD rate that was perhaps 10 times in excess of that same rate elsewhere in the country.

This multidisciplined approach was developed and implemented over a 4-year period of time, and heavy emphasis was placed on providing kids with the basic facts about venereal disease, as well as discussing venereal disease within a life context, not simply dispensing facts, and making them feel comfortable with the subject, comfortable with the fact that, if they engaged in sexual activity, there is a likelihood they will be affected, and, therefore, what to do about it.

The result of that 4-year program was a significant reduction. It was cut in half of that VD rate in San Francisco, and it was a tremendously successful venture. A number of things were studied, various new concepts in teaching, how to deal with it.

Peer group education was experimented with, and was found to be more effective than authority education. A number of other things

were dealt with. It was truly an experiment and some elements of it still exist.

Acting Chairman MEEDS. Are you aware of any curriculum being devised as a result of that?

Mr. KNOX. Yes.

Acting Chairman MEEDS. It was?

Mr KNOX. That is right.

Acting Chairman MEEDS. Is that available to you?

Mr. KNOX. It is in my office.

Acting Chairman MEEDS. Could you make it available to the committee?

Mr. KNOX. I certainly can.

Acting Chairman MEEDS. Could you give me some idea how big it is? What are we talking about in terms of——

Reverend MAHAR. Well, you know, a booklet like this might be some indication. Is that what you mean? Volume of stuff?

Acting Chairman MEEDS. Yes. I was wondering whether to make it a part of the record or part of the file. I think without objection we will make it part of the file at this point.

Reverend MAHAR. Mr. Chairman I would suggest that when you get digging around in this field in terms of what you have just brought up that you will find a number of things that actually have been produced and used on a trial and error basis, shotgun like, here and there, and they could at least be a point of departure for other persons as they start setting up research designs and that sort of thing.

I should like to say also that since we have singled out San Francisco, I wouldn't want anyone from San Francisco to feel that they had been held up as a bad example or something. Let me call to your attention in the 1975 Joint Report of the United States Public Health, American Social Health Organization, and other allied organizations on this whole problem of VD, there are maps and city listings. We have it all here, what the incidence of VD is around the country, so none of us has any reason to feel complacent about the whole thing.

Acting Chairman MEEDS. I am going to violate the first rule of a good lawyer, which is to never ask a question unless you know the answer. [Laughter.]

Reverend MAHAR. You have just put me out of business.

Acting Chairman MEEDS. And I am going to ask you what I consider to be a pretty tough question, particularly for a man of the cloth, and again particularly the Catholic cloth.

Do you think sex education should be a part of comprehensive health education?

Reverend MAHAR. Without question.

Acting Chairman MEEDS. Glad I asked.

Reverend MAHAR. And I think we are being ostriches, and that is an enormously unaesthetic posture. We are being ostriches if we ignore the reality of this aspect of human nature and we ignore the help that we profess we want to give people during their developmental years. I feel very strongly about this.

As long as we are going to talk about the Roman Catholics for a moment—and I would rather not—they are in enough trouble—there

are diocese that are introducing very comprehensive sex education programs. The chanceries are being picketed and everything else by the Roman Catholics because, you know, the minute you start, we are in trouble. All kinds of groups are going to be terribly exercised over this business.

Acting Chairman MEEDS. Thank you very much, Father. Chris?

Mr. CROSS. If I could just follow up on the San Francisco situation for a moment: in San Francisco who was involved in doing the teaching? Was it only educators? Did it involve some of the health professionals as well?

Reverend MAHAR. It followed the general technique of the American Social Health Association's presence in the community, number one, to enlist as many groups as possible to open up the consciousness; to enlist as many teachers as possible who registered some interest in a kind of in-service education thing; to get as many schools as possible involved.

Then it becomes a joint effort. Those teachers who now have shown that much interest that want to do some in-service education thing should get the right vocabulary. I think a lot of people are uncomfortable with a lot of subjects because they really don't have the adequate vocabulary and are a little embarrassed sometimes, particularly when you have got a very intimate, delicate question.

It is, therefore, a very comprehensive approach as far as the community is concerned. That doesn't mean that it didn't become controversial and that a lot of groups didn't get upset.

Mr. CROSS. That was my only question. Thank you.

Acting Chairman MEEDS. Thank you very much, Father.

Reverend MAHAR. Thank you for allowing us to be here.

Acting Chariman MEEDS. Our next witness is Ms. Florence Fenton, who is supervisor of health education, Prince Georges County Public Schools.

STATEMENT OF FLORENCE FENTON, SUPERVISOR, HEALTH EDUCATION, PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS, MD.

Mrs. FENTON. For the record, that is Mr. Fenton. I have decided this morning and have discovered this morning that one of the real disadvantages in being the last person to speak is that everything has been said.

Acting Chairman MEEDS. But you are not.

Mrs. FENTON. I am not? I thought there were four of us this morning.

Acting Chairman MEEDS. You would preempt some others.

Mrs. FENTON. I am sorry about it because I am probably going to pick up on those things that are left. The people that did speak earlier said most of the things that I did plan to say, because everything they said is true, so what I would like to do is take another approach with you.

I want a promise from you that when you go back and see the other members of the subcommittee that you will use this little strategy with them. OK?

Acting Chairman MEEDS. If it is good. [Laughter.]

Mrs. FENTON. I can't guarantee that it is good, but it usually generates a little bit of thought. When you were in elementary school, if you think about your elementary school, what was your health education program and health education in that elementary school setting?

I would venture to say that your response and perhaps other members of the committee will respond that they had a little bit of dental health, they learned to brush teeth, and they learned to wash hands periodically.

I don't know about your elementary school, but in my elementary school one of the first things that we did every morning was put our hands out and, if we had clean fingernails, we got an A in health for the week.

By the time most of us reached seventh grade, we were convinced that if we brushed our teeth and washed our hands periodically and had clean fingernails that we were destined to a life of good health.

We know that this is not true. As I perceive health education from some of the things that have been said here earlier this morning, it is a real stark indication that we are crisis-oriented.

Chris, you had mentioned earlier environmental health, consumer help, drug education, sex education. Yes, this is exactly what we have done through the years. We have plugged the gap and we have said: "OK. We have a drug problem. If we have a drug problem, let us have a drug education program. Let us support a little bit of legislation that way, and we will lick the problem," and we know that this is not true.

We are not saying to you that health education, comprehensive, sequential, quality health education, is going to be a panacea for all the ills of society today, but what we are saying is that this must be a priority. Here again, Chris, it must be a priority.

The report to the President from his committee on health education stipulated that over $75 billion a year is spent on health services, and we truly feel—we people that are in the educational component of health ed—feel that, if we can reach people early enough in life, help them deal with health behaviors, have them deal with decisions that relate to their health, their health behavior, their well-being, that this in turn will affect the health behavior and well-being of other individuals.

I will be happy to answer questions. I will be happy to state additional statistics, if you would like, but I don't want to belabor the point.

I think it is long overdue. It is $50 million that is involved here, is that correct?

Acting Chairman MEEDS. Various aspects. Yes. In the first 2 years.

Mrs. FENTON. When you consider the 3-year project that has been proposed, this is a drop in the bucket, and, if you can do something to help people start thinking about their own human needs, perceptions, values, self-concept, interpersonal relationship, the most important components is decisionmaking, how to make decisions, and you cannot do this by having a health education class that meets 10 minutes every Friday morning.

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We need it built-in. We need to have it comprehensive. We need to go beyond kindergarten, and we need to go prior to kindergarten, because these kids that we are dealing with today are going to be the parents of tomorrow and perhaps we won't need as much legislation in the area of funds for the handicapped and environmental health and consumer health if we can get to these people young enough so that their health behaviors become very positive for future generations

We like to say in Prince George's County that we deal with womb to tomb health education. [Laughter.]

Mrs. FENTON. And we are really very concerned about the aged. This is why we say health education doesn't stop at 12th grade. We are really concerned about the health behaviors of people as they grow, as they develop, as they become aged. There you have it.

Acting Chairman MEEDS. Florence, let me ask you a question which probably will invite a lot of the things that we are wondering about on the ground here.

As county supervisor for health education, let us assume that this law was passed and the University of Maryland and Prince George's County were told to develop a comprehensive health education program for counties like Prince George's.

Tell me what you would do.

Mrs. FENTON. OK. We have done much to date. We are not, you know, starting at the bottom. We have scratched the surface. We work very closely with the University of Maryland and the staff there. It is a reciprocal kind of thing really because we are so close to the university and it makes it very convenient.

What we would do is develop a program, as we have been working in the past, so that when these young people graduate from the University of Maryland with an undergraduate degree in health education they will come out fully prepared so that we do not have to do additional inservice with them when they come onboard.

In the United States to date we have less than 60 institutions of higher learning that offer degrees in health education. We also find that with our elementary school teachers, when they come out, they are certifiable in health in elementary education, but what we would like to see included in the undergraduate programs of these people would be more health education dealing with their own health behavior, and that would include dealing with their, the teachers', mental health, their physical health, their social health, their emotional health, getting these people in touch with their own being.

In the area of human sexuality, as Father mentioned, you know, many of these teachers have been—they have never learned to accept themselves as a sexual being, so it would be a real disadvantage for this teacher to go into the classroom and for someone to mandate that they must teach comprehensive sex ed programs.

I think by fortifying what goes on in our undergraduate schools, we can bring these people onboard. They will be better prepared to deal with the total health education program.

Acting Chairman MEEDS. What would you do with elementary educators? Would you suggest—do you think that an inservice-type program would be adequate to put them in a position to teach those

elements of health education—comprehensive health education—that occur in the elementary grades?

Mrs. FENTON. I am going to be candid with you.

Acting Chairman MEEDS. I assumed you had been all along.

Mrs. FENTON. You noticed that, right? Good. No. I think it is a disservice to teachers for us to constantly inservice them in this and inservice them in that. We inservice them in new math. We inservice them in everything that happens at the elementary level. New language art programs, no matter what it might be.

Teachers are human too. They don't have a lot of additional time in order to teach this, that, and the other that have to have additional inservice.

Now, what I would like to see is support inservice offered for teachers at an elementary school to bring them onboard when they are better prepared.

Now, as Lucille mentioned, what we are going to have to do for the next couple of years is continue to inservice teachers as we have been doing for the past number of years.

In the State of Washington, I believe Lucille said, since 1966 this has been happening. This is what we have been doing also in Prince George's County, which is the 10th largest school system in the United States. We have been inservicing until we are just blue in the face. It is not quality and there is no guarantee that this is going to produce a quality program, nor is it going to guarantee that when that teacher finishes the inservice program that they are going to be quality teachers in that area.

We would really like to get back to the beginning.

Acting Chairman MEEDS. Tell us about the health education program in Prince George's County.

Mrs. FENTON. In Prince George's County we are very pleased with our health education program, but we are far from where we really want to be. We have started with kindergarten through grade 12 health education programs.

In the elementary schools, we rely upon the elementary school teacher to incorporate it, as Chris has mentioned earlier before, in the ongoing curriculum, in the other things that are being taught.

We tell these elementary school teachers: "We don't care what you call it. You can call it language arts, and you can do it in language arts. You can teach many, many concepts of health, and they can be language arts related, or social studies, science." We say you can call it "Bananas," if you want to, as long as the kids get the tools that they need to make better decisions concerning their lives and their health.

In the junior high schools and the senior high schools, we do not want to prostitute ourselves by saying: "OK. This teacher or this science teacher—you will do a week on venereal disease education." That is not educationally sound. It is not a quality program. All you can do is tell them what venereal disease is, how you get it, and where you go to get it treated. That is not quality education.

What we are opting for in Prince George's County is certifiable health education teachers that graduate with degrees in health education.

They are given their room. They are given the same luxuries that other teachers have and they are the health educator on the staff of

that school, and they do not have to teach music half a day or French half a day, but they teach total health education.

Acting Chairman MEEDS. This is at the elementary level?

Mrs. FENTON. This is secondary now. We do not have coverage in all of our senior high schools or junior high schools at this stage, but we have made a pretty good niche in the number. We have approximately 60 secondary schools, and we have approximately 41 health ed programs in some of those schools.

Now, it sounds great, and it is going to look beautiful on your paper, but let me tell you about some of those. We have one of our schools where we have the health educator teaching perhaps two classes of health education the entire semester. OK. Reaches approximately 60 students out of a high school of 2,000. It is scratching the surface. This is a high school with a lot of problems, a lot of pregnancies, venereal disease. You name it; they have it.

We have been trying to get a total program in there and expand what now exists, but in the meantime he teaches science. We have some programs where the teacher might teach French. Lucky, aren't we, that we have a health educator that also happens to be able to teach French, music. We have been dovetailed with many, many other disciplines.

We are saying that we want to stand up now. We want to be counted and we want people to say: "Yes, this is a priority," and we really think we have something to offer and something we can do to help kids live better lives and be more productive for society and themselves.

Acting Chairman MEEDS. Do you have a comprehensive curriculum for health education in Prince George's County?

Mrs. FENTON. Yes, and that is also very interesting. In the State of Maryland, this was the first time that any curriculum has been developed at State level and then filtered down to the counties. Now, not all of the counties in the State of Maryland are utilizing it, but we have adopted this particular curriculum, and it is called the "Curricula Approach to Optimal Health," and I will be happy to send you a set of the curriculum if you would like to peruse it.

Acting Chairman MEEDS. Would you do that? Without objection, that will be made part of the file in this proceeding.

Mrs. FENTON. Beautiful. Great.

Acting Chairman MEEDS. Chris?

Mr. CROSS. I am curious and very interested in your approach. You really seem to feel the need for some certification for the teachers. It seems to me that with the subject matter involved that that does make a great deal of sense.

You mentioned there are 60 schools in the country that have a curriculum in health education?

Mrs. FENTON. Institutions of higher learning that give degrees in health education.

Mr. CROSS. What level is that? M.A.? B.A.?

Mrs FENTON. B.A

Mr. CROSS. Do you happen to have a list of those schools?

Mrs. FENTON. I don't, but I will be happy to get one for you.

Acting Chairman MEEDS. Without objection, that will be made part of the record at this point.

[The document follows:]

AAHE Directory of Institutions Offering Specialization in Health Education

As health education programs continue to be developed throughout the country there is much interest concerning which colleges and universities offer programs of specialization in health education. The last major directory of this type was compiled and circulated by the School Health Education Study in 1970, and the Association for the Advancement of Health Education undertook a revision as one of its first contributions to the profession. Robert H. Kirk, University of Tennessee, Knoxville, conducted the initial survey and follow-up inquiries were made by the AAHE headquarters staff. To the best of our knowledge, only separate programs in health education (or programs in health education and safety education) are included.

A phenomenal increase in new programs has occurred since 1970. According to returns as of August 1974, the number of bachelor programs has grown from 87 in 1970 (and only 38 in 1949) to 165 in 1974—an 89.6% increase. Figures for 1974 show a total of 179 colleges and universities in 41 states offering major programs in health education (as contrasted with 104 institutions in 31 states in 1970).

B = Bachelor
M = Master
S = Specialist (or sixth year)
D = Doctorate
1 = B-Community Health
2 = M-Community Health
3 = D-Community Health
* = New program since 1970

ALABAMA

AUBURN UNIVERSITY—Auburn 36830 (B,M,S*)
Richard K. Means, Ed.D., Professor, Health Education, Department of Health, Physical Education, and Recreation, School of Education

ARIZONA

ARIZONA STATE UNIVERSITY—Tempe 85281 (B,M)
Jack V. Toohey, Ed.D., Chairman of Health Education, Department of Health, Physical Education, and Recreation, College of Liberal Arts

UNIVERSITY OF ARIZONA—Tucson 85721 (B,M)
William H. King, D.Ed., Professor and Area Chairman, Health Education, Department of Athletics, Health, Physical Education, and Recreation, College of Education

ARKANSAS

STATE COLLEGE OF ARKANSAS—Conway 72032 (B,M)
Arvil W. Burks, Ed.D., Coordinator of Health Education, Department of Health and Physical Education, College of Fine and Applied Arts and Sciences

UNIVERSITY OF ARKANSAS—Fayetteville 72701 (M,S*)
Charles D. Hundley, Ph.D., Chairman, Division of Health Education, College of Education

CALIFORNIA

CALIFORNIA STATE UNIVERSITY—Long Beach 90840 (B,M*) (1)
John A. Torney, III, Ed.D., Chairman, Health Science Department, School of Applied Arts and Sciences

California, continued

CALIFORNIA STATE UNIVERSITY—Los Angeles 90032 (B,M) (1)
Saxon C. Elliot, M.S., Ed.M., Chairman, Department of Health and Safety Studies, College of Professional Studies

CALIFORNIA STATE UNIVERSITY—Northridge 91324 (B,M) (1,2)
Claude T. Cook, Ed.D., Chairman, Department of Health Science, School of Communication and Professional Studies

CALIFORNIA STATE UNIVERSITY—Sacramento 95819 (B,M) (1,2)
Florence B. Benell, M.S.P.H., Ph.D., Chairman and Professor, Department of Health and Safety Studies, Division of Health, Physical Education, and Recreation

CALIFORNIA STATE UNIVERSITY—San Jose 95192 (B,M) (2)
Sam Radelfinger, Ed.D., Chairman, Department of Health Science, School of Applied Sciences and Arts

FRESNO STATE COLLEGE—Fresno 94506 (B,M)
Henry F. Tricker, Ed.D., Chairman, Department of Health Science, School of Professional Studies

LOMA LINDA UNIVERSITY—Loma Linda 92399 (M) (2)
James Crawford, H.S.D., Chairman, Health Education Department, School of Health

SAN DIEGO STATE UNIVERSITY—San Diego 92115 (B,M) (1*)
William C. Burgess, Ed.D., Chairman, Health Science and Safety Department, College of Professional Studies

SAN FRANCISCO STATE UNIVERSITY—San Francisco 94132 (B,M) (1)
H. J. Weddle, M.P.H., Chairman, Department of Health Education, Division of Health, Physical Education, and Recreation

UNIVERSITY OF CALIFORNIA—Berkeley 94720 (M,D)
William Griffiths, Ph.D., Chairman, Program in Health Education, School of Public Health

UNIVERSITY OF CALIFORNIA—Los Angeles 90024 (B,M,D)
Edward B. Johns, Ed.D., Associate Head and Professor, Division of Behavioral Sciences and Health Education, School of Public Health

UNIVERSITY OF THE PACIFIC—Stockton 95024 (M)
Elizabeth Matson, M.S.P.H., Professor, Department of Health, Physical Education, and Recreation, Liberal Arts School

UNIVERSITY OF SOUTHERN CALIFORNIA—Los Angeles 90007 (M,D)
Lennie C. Smith, Ph.D., Professor of Health and Physical Education, Department of Physical Education, Graduate School

COLORADO

UNIVERSITY OF NORTHERN COLORADO—Greeley 80631 (B,M,D)
Bryan Cooke, Ph.D., Chairman, Health Education, School of Health, Physical Education, and Recreation

CONNECTICUT

SOUTHERN CONNECTICUT STATE COLLEGE—New Haven 06515 (B* M*)
Jerry L. Ainsworth, Ed.D., Coordinator, Division of Health, Physical Education, and Recreation

UNIVERSITY OF BRIDGEPORT—Bridgeport 06602 (B*)
Helen A. Spencer, Ed.D., Director, Arnold College Division

UNIVERSITY OF CONNECTICUT—Storrs 06268 (B)
James A. Bales, Ph.D., Supervisor, Health Education Curriculum, School of Physical Education

WESTERN CONNECTICUT STATE COLLEGE—Danbury 06810 (B*)
Alice Connelly, Ed.D., Acting Chairman, Health Education Department

DELAWARE

DELAWARE STATE COLLEGE—Dover 19901 (B)
Tommy L. Frederick, H.S.D., Chairman, Department of Health and Physical Education

FLORIDA

FLORIDA INTERNATIONAL UNIVERSITY—Miami 33144 (B*, M*)
Paul A. Bennett, Ed.D., Assistant Professor, Division of Health, Physical Education, Recreation, and Athletics, School of Education

FLORIDA STATE UNIVERSITY—Tallahassee 32306 (B*,M*)
Marion C. Riser, Ph.D., Specialization Coordinator, Associate Professor, Division of Professional and Clinical Programs, College of Education

UNIVERSITY OF FLORIDA—Gainesville 32601 (B,M)
Dora A. Hicks, D.Ed., Chairman of Health Education, Department of Professional Curriculum, College of Physical Education and Health

UNIVERSITY OF NORTH FLORIDA—Jacksonville 32216 (B*)
Jack R. Neicher, H.S.D., Chairman, Department of Health and Physical Education, College of Education

UNIVERSITY OF SOUTH FLORIDA—Tampa 33620 (B*)
Rita G. Bruce, Ed.D., Coordinator of Health Education, College of Education

UNIVERSITY OF WEST FLORIDA—Pensacola 32504 (B*)
Luther C. Schwick, Ph.D., Chairman, Health, Leisure, and Sports Department

GEORGIA

GEORGIA COLLEGE—Milledgeville 31061 (B*)
Sam James, Ed.D., Chairman of Health Education, Department of Health, Physical Education, and Recreation

UNIVERSITY OF GEORGIA—Athens 30602 (B,M)
Ralph H. Johnson, Ed.D., Division of Health, Physical Education, and Recreation, College of Education

ILLINOIS

CHICAGO STATE UNIVERSITY—Chicago 60628 (B*)
Wayne Worick, H.S.D., Associate Professor and Coordinator of Health and Safety Education, Department of Health, Physical Education, and Recreation

EASTERN ILLINOIS UNIVERSITY—Charleston 61920 (B*)
Jack J. Richardson, Ed.D., Coordinator, Health Education

GEORGE WILLIAMS COLLEGE—Downers Grove 60515 (B*,M)
Bradley L. Rothermel, Ph.D., Director, Division of Health and Physical Education

NORTHWESTERN UNIVERSITY—Evanston 60201 (B,M)
Walter H. Gregg, Ed.D., Chairman, Department of Physical and Health Education, School of Education

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* — New program since 1970

SOUTHERN ILLINOIS UNIVERSITY—Carbondale 62901 (B,M) (1,2)
Donald C. Poulston, Ed.D., Chairman, Department of Health Education, College of Education

UNIVERSITY OF ILLINOIS—Champaign 61820 (B,M,D) (1)
William H. Creswell, Jr., Ed.D., Head, Department of Health and Safety Education, College of Physical Education

WESTERN ILLINOIS UNIVERSITY—Macomb 61455 (B)
Robert J. Synovitz, H.S.D., Chairman, Department of Health and Safety Education, College of Physical Education

INDIANA

ANDERSON COLLEGE—Anderson 46011 (B)
James D. Macholtz, P.E.D., Chairman, Department of Physical Education

BALL STATE UNIVERSITY—Muncie 47868 (B,M,S) (2)
Warren E. Schaller, H.S.D., Chairman, Department of Physiology and Health Science, College of Sciences and Humanities

INDIANA CENTRAL COLLEGE—Indianapolis 46227 (B)
Angus Nicoson, M.A., Chairman, Health and Physical Education Department

INDIANA STATE UNIVERSITY—Terre Haute 47809 (B,M) (1)
Richard D. Spear, H.S.D., Chairman, Department of Health and Safety, School of Health, Physical Education, and Recreation

INDIANA UNIVERSITY—Bloomington 47401 (B,M,S,D) (2)
Donald L. Ludwig, H.S.D., Chairman, Department of Health and Safety Education, School of Health, Physical Education, and Recreation

MANCHESTER COLLEGE—North Manchester 46962 (B)
Don Meek, M.A., Associate Professor, Health Education Program

PURDUE UNIVERSITY—West Lafayette 47907 (B,M,D)
C. Harold Veenker, H.S.D., Chairman, Health Education Section, Department of Physical Education for Men, School of Humanities, Social Science and Education

KANSAS

KANSAS STATE UNIVERSITY—Manhattan 66506 (B*)
Dennis Beltz, Ph.D., health education program coordinator, Department of Health, Physical Education, and Recreation

UNIVERSITY OF KANSAS—Lawrence 66044 (B*,M*)
Phillip G. Huntsinger, Ed.D., Associate Professor, Department of Health, Physical Education, and Recreation, School of Education

KENTUCKY

CUMBERLAND COLLEGE—Williamsburg 40769 (B*)
John E. Renfro, Ed.D., Head, Department of Health

EASTERN KENTUCKY UNIVERSITY—Richmond 40475 (B,M*) (1)
Herman Bush, H.S.D., Chairman, Department of School and Public Health

MOREHEAD STATE UNIVERSITY—Morehead 40351 (B)
Harry Sweeny, Ed.D., Department of Health, Physical Education, and Recreation

UNIVERSITY OF KENTUCKY—Lexington 40506 (B,M*) (1,2)
Phyllis Sandidge, H.S.D., Assistant Professor, Department of Health, Physical Education, and Recreation, College of Education
Joe Fred Sills, M.P.H., Ph.D., Chairman, Department of Community Health, College of Allied Health Professions

WESTERN KENTUCKY UNIVERSITY—Bowling Green 42101 (B,M) (1)
J. David Dunn, M.P.H., D.Sc., Head, Department of Health and Safety, College of Applied Arts and Health

LOUISIANA

LOUISIANA STATE UNIVERSITY—Baton Rouge 70803 (B,M,D)
Curtis R. Emory, Ed.D., Department of Health

SOUTHERN UNIVERSITY—Baton Rouge 70813 (B)
Clifford T. Seymour, R.E.Dir., Acting Chairman, Department of Health and Safety, Division of Health, Physical Education, and Recreation, College of Education

MARYLAND

MORGAN STATE COLLEGE—Baltimore 21239 (B)
Kenneth Brown, A.M., Acting Chairperson, Department of Health, Physical Education and Recreation, Division of Natural Sciences

TOWSON STATE COLLEGE—Towson 21204 (B,M) (1)
Clint E. Bruess, Ed.D., Chairman, Department of Health Science, Division of Health and Physical Education

UNIVERSITY OF MARYLAND—College Park 20742 (B,M,D)
John Burt, Ed.D., Chairman, Department of Health Education, College of Physical Education, Recreation and Health

MASSACHUSETTS

BOSTON UNIVERSITY—Boston 02215 (M,D)
Carl E. Willgoose, Ed.D., Professor of Education, Department of Human Movement and Health Education, School of Education

BRIDGEWATER STATE COLLEGE—Bridgewater 02324 (M*)
Henry Burney, H.S.D., Health Coordinator, Health and Physical Education Department

LOWELL STATE COLLEGE—Lowell 01854 (B)
Gertrude Barker, Ed.D., Dean, School of Health Professions

NORTHEASTERN UNIVERSITY—Boston 02115 (B)
H. Marie Garrity, Ed.D., Executive Officer, Department of Health Education

SPRINGFIELD COLLEGE—Springfield 01109 (B)
Harold M. Childs, Ed.D., Professor and Director of Health Education, Division of Health, Physical Education, and Recreation

UNIVERSITY OF MASSACHUSETTS—Amherst 01002 (M) (1,2)
William A. Danty, Ph.D., Professor of Public Health and Head, Department of Public Health (joint master's program with School of Education)

MICHIGAN

CENTRAL MICHIGAN UNIVERSITY—Mount Pleasant 48858 (B,M) (1)
Frank H. Myers, H.S.D., Chairman, Department of Health Education, School of Health, Physical Education, and Recreation

MICHIGAN STATE UNIVERSITY—East Lansing 48823 (B,M,D)
Joseph G. Dzenowagis, Ed.D., Coordinator of Health Education, Department of Health, Physical Education, and Recreation, College of Education

Michigan, continued

NORTHERN MICHIGAN UNIVERSITY—Marquette 49855 (B*)
William R. Taggart, Ph.D., Coordinator of Health Science, Department of Health, Physical Education, and Recreation

UNIVERSITY OF MICHIGAN—Ann Arbor 48104 (B,M,D) (2)
Scott K. Simonds, Dr.P.H., Professor and Director of Program, School of Public Health; E. J. McClendon, Ed.D., Director of Program, School of Education

WAYNE STATE UNIVERSITY—Detroit 48202 (M)
Gertrude B. Couch, Ph.D., Chairman of Health Education, Division of Health and Physical Education, College of Education

WESTERN MICHIGAN UNIVERSITY—Kalamazoo 49008 (B*)
Margaret Large, Ph.D., Chairman of Health Education

MINNESOTA

BEMIDJI STATE COLLEGE—Bemidji 56601 (B)
Robert Montebello, Ed.D., Chairman, Department of Health, Safety, and Recreation, Division of Health, Physical Education and Recreation

MANKATO STATE COLLEGE—Mankato 56001 (B,M) (1)
Robert Samuel Cobb, M.A., Ph.D., Chairman, Health Science Department, Division of Health and Physical Education

MOORHEAD STATE COLLEGE—Moorhead 56560 (B)
Mary V. Montgomery, M.Ed., Director, Health and Safety, Coordinator of Health Education, Department of Health, Physical Education and Recreation

ST. CLOUD STATE COLLEGE—St. Cloud 56301 (B,M*)
George Serdula, H.S.D., Ed.D., Director of Health Education, Health, Physical Education, and Recreation Department, School of Education

ST. OLAF COLLEGE—Northfield 55057 (B,*)
Edlo Solum, Chairman of Health Education

SOUTHWEST MINNESOTA STATE COLLEGE—Marshall 56258 (B)
Eugene W. Anderson, Ed.D., Chairman, Division of Health and Physical Education

UNIVERSITY OF MINNESOTA—Minneapolis 55455 (B,M,D) (2)
Helen M. Slocum, Ph.D., Chairman, Department of School Health Education, School of Physical Education and Recreation, College of Education
Norman Craig, M.P.H., Associate Professor, Health Education, School of Public Health

WINONA STATE COLLEGE—Winona 55987 (B)
Richard Behnke, Ed.D., Health Program Supervisor, Department of Health, Physical Education, and Recreation

MISSISSIPPI

UNIVERSITY OF SOUTHERN MISSISSIPPI—Hattiesburg 39401 (B*,M*)
W. L. Carr, Ed.D., Chairman, Health Education, School of Health, Physical Education and Recreation

MISSOURI

CENTRAL MISSOURI STATE UNIVERSITY—Warrensburg 64093 (B*)
H. L. Yinger, Ed.D., Division Chairman, Division of Health, Physical Education and Recreation

B — Bachelor
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* — New program since 1970

NORTHEAST MISSOURI STATE UNIVERSITY—Kirksville 63501 (B*, M*)
C. G. Fast, Professor of Health Education, Department of Health and Physical Educaton

UNIVERSITY OF MISSOURI—Columbia 65201 (B*,M*)
Colin E. Boy, H.S.D., Director, Health Education, Department of Health and Physical Education, College of Education

MONTANA

MONTANA STATE UNIVERSITY—Bozeman 59715 (B*)
George Shroyer, Ed.D., Chairman, Department of Physical Education

NEBRASKA

CHADRON STATE COLLEGE—Chadron 69337 (B*)
Thomas P. Colgate, Ph.D., Chairman of Physical Education Division, School of Education and Physical Education (designed to extend the RN diploma program into health education and/or school nursing)

KEARNEY STATE COLLEGE—Kearney 68847 (B*)
Donald Lackey, Ed.D., Health and Physical Education

UNIVERSITY OF NEBRASKA—Lincoln 68508 (B*)
Ian M. Newman, Ph.D., Associate Professor and Chairman, Department of Education and Medical Administration, Division of Community Health Education

NEVADA

UNIVERSITY OF NEVADA—Reno 89507 (B)
Gerald W. Matheson, M.A., Assistant Professor, Health Sciences Program

NEW JERSEY

GLASSBORO STATE COLLEGE—Glassboro 08028 (B*)
Pearl Britton, Ed.D., Coordinator of Health, Health Curriculum

JERSEY CITY STATE COLLEGE—Jersey City 07305 (B,M) (1,2)
Donald R. Cicero, Chairman, Department of Health Sciences

MONTCLAIR STATE COLLEGE—Upper Montclair 07043 (B,M)
Harry H. Holtsma, Ed.D., Chairman, School of Professional Arts and Sciences, Department of Health Professions

RAMAPO COLLEGE OF NEW JERSEY—Mahwah 07430 (B)
Rosabel S. Koss, Ed.D., Professor of Health and Physical Education, School of Theoretical and Applied Science and Division of Teacher Education

TRENTON STATE COLLEGE—Trenton 08625 (B,M)
William Fassbender, Ed.D., Director of Health Education, Department of Health and Physical Education, School of Education

NEW MEXICO

UNIVERSITY OF NEW MEXICO—Albuquerque 87131 (B,M,D) (2)
Ella May Small, Ed.D., Professor and Coordinator, Health Education, Division of Health, Physical Education and Recreation, College of Education

NEW YORK

ADELPHI UNIVERSITY—Garden City 11530 (M)
Gerald Edwards, Ed.D., Chairman, Department of Health and Physical Education, Graduate School of Arts and Sciences

BROOKLYN COLLEGE OF CITY UNIVERSITY OF NEW YORK—Brooklyn 11210 (B,M)
Frank Rathbone, Ed.D., Director of Health Sciences, Department of Health and Physical Education

CORNELL UNIVERSITY, NEW YORK STATE COLLEGE OF HUMAN ECOLOGY—Ithaca 14850 (B,M,D) (1,2,3)
John Ford, M.P.H., M.S.W., Ph.D., Community Service Education

HERBERT H. LEHMAN COLLEGE OF CITY UNIVERSITY OF NEW YORK—New York (Bronx) 10468 (B,M)
David Katz, Ph.D., Coordinator, Health Division, Department of Health, Physical Education, and Recreation

HUNTER COLLEGE OF CITY UNIVERSITY OF NEW YORK—New York 10021 (B,M)
Andrew J. J. Brennan, Ph.D., Coordinator of Health Education, Department of Health and Physical Education

NEW YORK UNIVERSITY—New York 10003 (B,M,D)
Marian V. Hamburg, Ed.D., Director of Health Education, Division of Health Education, Physical Education, and Leisure Studies

QUEENS COLLEGE—Flushing 11367 (B*)
Madeline Hurster, Ph.D., Coordinator, Health and Physical Education Department

RUSSELL SAGE COLLEGE—Troy 12180 (B*,M*) (3)
Miriam L. Tuck, Ed.D., P.H.N., Director of Health Education

STATE UNIVERSITY COLLEGE—Brockport 14420 (B,M)
William H. Zimmerli, Ed.D., Acting Chairman, Department of Health Science

STATE UNIVERSITY COLLEGE—Cortland 13045 (B,M)
Charles N. Poskanzer, M.P.H., Ed.D., Chairman, Health Department, Division of Health, Physical Education and Recreation

STATE UNIVERSITY COLLEGE—Plattsburgh 12901 (B*)
Ernest P. Rangazas, Ed.D., Chairman, Division of Health, Physical Education and Recreation

STATE UNIVERSITY OF NEW YORK—Buffalo 14214 (M*,D*)
Jerrold S. Greenberg, Ed.D., Coordinator, Health Education, School of Health Education

STATE UNIVERSITY OF NEW YORK—Stony Brook 11790 (B*)
Stanley Zimering, M.P.H., Chairman, Division of Community/Mental Health

SYRACUSE UNIVERSITY—Syracuse 13210 (B,M,D)
Peter P. Cataldi, Ed.D., Assistant Chairman, Health, Recreation, and Physical Education, Arts and Sciences, and School of Education

TEACHERS COLLEGE, COLUMBIA UNIVERSITY—New York 10027 (M,D) (2)
James L. Malfetti, Ed.D., Chairman, Department of Health Education, Division V, Health Services, Science and Education

WAGNER COLLEGE—Staten Island 10301 (B*,M*)
Glenn C. Leach, Ed.D., Coordinator of Health Education, Department of Education

NORTH CAROLINA

APPALACHIAN STATE UNIVERSITY—Boone 28607 (B*)
Lawrence E. Horne, Ed.D., Chairman, Department of Health, Physical Education and Recreation, College of Fine and Applied Arts

EAST CAROLINA UNIVERSITY—Greenville 27834 (B)
Thomas H. Johnson, Ph.D., Coordinator of School and Community Health Education, Department of Health and Physical Education, College of Arts and Sciences

NORTH CAROLINA CENTRAL UNIVERSITY—Durham 27707 (B)
Howard M. Fitts, Jr., M.S.P.H., Ed.D., Chairman, Department of Health Education, College of Arts and Sciences

UNIVERSITY OF NORTH CAROLINA—Chapel Hill 27514 (B,M,D) (2,3)
Guy W. Steuart, M.P.H., Ph.D., Chairman, Department of Health Education, School of Public Health

UNIVERSITY OF NORTH CAROLINA—Greensboro 27412 (B,M) (1)
Marian K. Solleder, Ph.D., Coordinator, Health Education Division, School of Health, Physical Education and Recreation

WESTERN CAROLINA UNIVERSITY—Cullowhee 28723 (B*)
Helen M. Hartshorn, Ed.D., Director, Community Health Education and Recreation Department, School of Education and Psychology

NORTH DAKOTA

NORTH DAKOTA STATE UNIVERSITY—Fargo 58102 (B*)
Roger D. Kerns, Chairman of Physical Education, Department of Physical Education and Athletics

OHIO[1]

KENT STATE UNIVERSITY—Kent 44242 (B,M) (1,2)
Rosemary Amos, Ed.D., M.P.H., Chairman, Department of Allied Health Sciences, School of Health, Physical Education, and Recreation

MIAMI UNIVERSITY—Oxford 45056 (B)
Richard T. Mackey, Ed.D., Professor, Health and Physical Education, Department of Health and Physical Education for Men, School of Education

OHIO STATE UNIVERSITY—Columbus 43210 (B,M,D)
Robert Kaplan, Ph.D., Chairman, School of Health, Physical Education, and Recreation

UNIVERSITY OF CINCINNATI—Cincinnati 45221 (B)
Mary E. Wolverton, Ed.D., Coordinator of Women's Division, Health, Physical Education and Recreation Department, College of Education

UNIVERSITY OF TOLEDO—Toledo 43606 (B,M,D) (1)
Gere B. Fulton, Ph.D., Chairman of Department of Health Education

[1] *The following institutions in Ohio also have health specializations, most of them bachelor programs added since 1970, but it was not possible to get complete information before press time.*

ASHLAND COLLEGE—Ashland 44805
BOWLING GREEN UNIVERSITY—Bowling Green 43402
CENTRAL STATE UNIVERSITY—Wilberforce 45384
FINDLAY COLLEGE—Findlay 45840
LAKE ERIE COLLEGE—Painesville 44077
MUSKINGUM COLLEGE—New Concord 43762
OHIO NORTHERN UNIVERSITY—Ada 45810
OHIO UNIVERSITY—Athens 45701
OHIO WESLEYAN UNIVERSITY—Delaware 43015
OTTERBEIN COLLEGE—Westerville 43081
RIO GRANDE COLLEGE—Rio Grande 45674
UNIVERSITY OF AKRON—Akron 44325
UNIVERSITY OF DAYTON—Dayton 45469
WITTENBERG UNIVERSITY—Springfield 45501
YOUNGSTOWN UNIVERSITY—Youngstown 44503

OREGON

LEWIS AND CLARK COLLEGE—Portland 97219 (B*,M*)
Dell Smith, Ed.M., Chairman, Department of Health and Physical Education

OREGON STATE UNIVERSITY—Corvallis 97331 (B,M,D) (1,2)
Arthur Koski, Ed.D., Head, Department of Health Education, Division of Physical Education, School of Education

PORTLAND STATE UNIVERSITY—Portland 97207 (B,M*)
Michael W. Tichy, Ed.D., Executive Officer for Health Education, Department of Health and Physical Education

UNIVERSITY OF OREGON—Eugene 97403 (B,M,D) (1)
Warren E. Smith, Ed.D., Professor, Department Head of Health Education, College of Health, Physical Education and Recreation

PENNSYLVANIA

PENNSYLVANIA STATE UNIVERSITY—University Park 16802 (B*,M*)
Kenneth S. Clarke, Ph.D., Chairman, Health Education

SLIPPERY ROCK STATE COLLEGE—Slippery Rock 16057 (B*, M*)
Russell F. Whaley, M.P.H., Ph.D., Department of Health Science, School of Health, Physical Education, and Recreation

TEMPLE UNIVERSITY—Philadelphia 19122 (B,M,D) (2,3)
Marvin R. Levy, Ed.D., Chairman of Health Education, Department of Health Education, College of Health, Physical Education, Recreation, and Dance

UNIVERSITY OF PITTSBURGH—Pittsburgh 15213 (M*,D*) (2)
Herschel E. Griffin, Dr.P.H., Dean, Graduate School of Public Health
Karl C. H. Oermann, Ed.D., Chairman, Department of Health, Physical Education and Recreation

WEST CHESTER STATE COLLEGE—West Chester 19380 (B)
Walter E. Funk, M.S., Chairman, Department of Health Education, West

RHODE ISLAND

RHODE ISLAND COLLEGE—Providence 02908 (B*)
Nelson F. Wood, Ed.D., Assistant Professor of Health Education, Health and Physical Education Department

SOUTH CAROLINA

UNIVERSITY OF SOUTH CAROLINA—Columbia 29208 (B*, M*)
Marion T. Carr, H.S.D., Coordinator of Health Education, College of Health Sciences

TENNESSEE

EAST TENNESSEE STATE UNIVERSITY—Johnson City 37601 (B)(1)
Jay L. Allen, M.P.H., Chairman, Department of Health Education, College of Health

MEMPHIS STATE UNIVERSITY—Memphis 38118 (B*,M)
David I. Anspaugh, P.E.D., Department of Health, Physical Education, and Recreation

UNIVERSITY OF TENNESSEE—Knoxville 37916 (B,M,D) (1,2,3)
Robert H. Kirk, H.S.D., Head, Health and Safety Department, School of Health, Physical Education and Recreation, College of Education

B — Bachelor
M — Master
S — Specialist (or sixth year)
D — Doctorate
1 — B Community Health
2 — M Community Health
3 — D Community Health
* — New program since 1970

TEXAS

BAYLOR UNIVERSITY—Waco 76701 (B)
Jack E. Hansma, Ed.D., Director, Health Education, Department of Health, Physical Education and Recreation, College of Arts and Sciences, School of Education

EAST TEXAS STATE UNIVERSITY—Commerce 75428 (B*)
Ken Morgan, Ed.D., Health Education Coordinator, Department of Health and Physical Education

LAMAR UNIVERSITY—Beaumont 77710 (B*,M)
Alice C. Bell, Ph.D., Coordinator, Health Education, Department of Women's Health, Physical Education and Recreation Department, College of Education

NORTH TEXAS STATE UNIVERSITY—Denton 76203 (B,M*)
Bryan Gray, Ed.D., Assistant Professor, Department of Health, Physical Education and Recreation, College of Education

PAN AMERICAN UNIVERSITY—Edinburg 78539 (B*)
Darrel Stack, Ph.D., Head, Department of Health and Physical Education

SAM HOUSTON STATE UNIVERSITY—Huntsville 77340 (B, M) (1,2)
Ruth Cady, Ed.D., Coordinator of Health Education, Department of Health and Physical Education for Women

SOUTHWEST TEXAS STATE UNIVERSITY—San Marcos 78666 (B)
M. O. Juel, Ph.D., Coordinator, Health Instruction Program, Health and Physical Education Department

STEPHEN F. AUSTIN STATE UNIVERSITY—Nacogdoches 75961 (B)
Lucille Norton, Ed.D., Professor, Health and Physical Education Department, School of Education

TEXAS A & M UNIVERSITY—College Station 77843 (B,M,D)
Linus J. Dowell, D.Ed., Professor of Health and Physical Education, Department of Health and Physical Education, College of Education

TEXAS SOUTHERN UNIVERSITY—Houston 77004 (B,M)
Edward P. Norris, P.E.D., Acting Division Chairman, Division of Health, Physical Education, and Recreation, College of Arts and Sciences

TEXAS WOMAN'S UNIVERSITY—Denton 76204 (B,M,D)
Donald J. Merki, Ph.D., Chairman, Health Education Department, College of Health, Physical Education, and Recreation

UNIVERSITY OF TEXAS—Austin 78712 (B,M,D)
Jessie Helen Haag, Ed.D., Professor, Health Education, Department of Health, Physical Education, and Recreation, College of Education

UNIVERSITY OF TEXAS AT EL PASO—El Paso 79968 (B,M)
William H. Harris, Ed.D., Coordinator of Health Education, Department of Health and Physical Education

WEST TEXAS STATE UNIVERSITY—Canyon 79016 (B*)
Myron H. Dees, Ed.D., Head, Department of Health and Physical Education

UTAH

BRIGHAM YOUNG UNIVERSITY—Provo 84602 (B,M) (1,2)
Ray Watters, H.S.D., Chairman, Department of Health Sciences, College of Physical Education

UNIVERSITY OF UTAH—Salt Lake City 84112 (B,M,D*)
Marshall W. Kreuter, Ph.D., Coordinator of Health Education, College of Health

UTAH STATE UNIVERSITY—Logan 84321 (B,M*)
Janice Pearce, Ph.D., Chairman of Health Education, Department of Health, Physical Education, and Recreation, College of Education

VERMONT

UNIVERSITY OF VERMONT—Burlington 05401 (B*)
Bob Gobin, Ph.D., Coordinator of Health Education, Department of Health, Physical Education, and Recreation

VIRGINIA

MADISON COLLEGE—Harrisonburg 22801 (B)
Thomas Hurt, Ed.D., Coordinator of Health Education

UNIVERSITY OF VIRGINIA—Charlottesville 22903 (B*,M*)
Patrick J. Bird, Ph.D., Chairman, Department of Health, Physical Education, and Recreation, School of Education

WASHINGTON

CENTRAL WASHINGTON STATE COLLEGE—Ellensburg 98926 (B,M)
Wilma Moore, Ed.D., Director of Health Education, Department of Health, Physical Education, and Recreation, School of Professional Studies

EASTERN WASHINGTON STATE COLLEGE—Cheney 99004 (B)
Richard H. Hagelin, Ph.D., Professor and Chairman of Health, School of Human Development

UNIVERSITY OF WASHINGTON—Seattle 98105 (B,M)
Joseph Patterson, Dr.P.H., Faculty Advisor for Health Education, Assistant Professor, Department of Preventive Medicine and the Department for Women, School of Physical and Health Education

WEST VIRGINIA

WEST LIBERTY STATE COLLEGE—West Liberty 26074 (B*)
Harriet E. Ream, M.A., Associate Professor, Health Education, School of Health and Physical Education

WEST VIRGINIA STATE COLLEGE—Institute 25112 (B)
Richard D. Tredway, Ed.D., Chairman, Health, Physical Education, Recreation, and Safety Department, Social Sciences and Philosophy Division

WEST VIRGINIA UNIVERSITY—Morgantown 26506 (B,M,D)
Robert A. Walker, Ed.D., Acting Chairperson, College of Human Resources and Education

WISCONSIN

UNIVERSITY OF WISCONSIN-EAU CLAIRE—Eau Claire 54701 (B*)
John B. Gerberich, Ed.D., Chairman, Division of Allied Health Programs

UNIVERSITY OF WISCONSIN-LA CROSSE—La Crosse 54601 (B,M*)
Richard J. Hardy, Ph.D., Chairman, Health Education Department, School of Health Education, Physical Education, and Recreation

UNIVERSITY OF WISCONSIN-MADISON—Madison 53706 (M,D)
Warren H. Southworth, Dr.P.H., Professor of Health Education, Department of Curriculum and Instruction, School of Education

We recognize that it is difficult to obtain complete and correct information for a listing of this type. If your program has been omitted, or if the information presented here is not accurate, please let us know. Send appropriate details to: AAHE Directory, Attn: John H. Cooper, 1201 16th St., N.W., Washington, D.C. 20036.

AAHE ACTIVITIES

Highlights of Action at the Spring Board of Directors Meeting

Members of the Board of Directors of the Association for the Advancement of Health Education met at the Alliance headquarters in Washington, D.C. on April 19-21, 1974. Noted here are highlights of the decisions made and action taken by the Board, to keep all AAHE members informed of the professional activities of their association.

Directed themselves, as individuals who occupy positions of leadership in the AAHE, to make a special effort to recruit new members for the Association through their opportunities for direct personal contact with professionals and students.

Designated a student theme for the year—SUNRISE 74-75 (SUN = Students, Unite, Now and RISE = Rise to the challenge of professional involvement) and noted that any program, promotional materials, etc. developed for recruiting and organizing student members for AAHE be designed around the theme.

Approved the AAHE budget as presented.

Charged the Executive Committee (or a committee appointed by it) to establish what relationships AAHE will assume with AAHPER districts and state associations.

Asked that a set of guidelines be established for financial assistance to state and district associations and stated that no requests for financial aid will be considered until such guidelines are approved.

Endorsed the recommendations of John Cooper with regard to the concept of voluntary field consultants in the work of AAHE.

Made the Committee on Completed Research in Health Education a continuing committee of the Association, to issue a report of its work biannually.

Continued the affiliation of AAHE with the Coalition of National Associations of Health Education, with ten official delegates and an alternate to be designated.

Directed the Honor Awards Committee to continue development of the overall awards program and to implement the criteria and procedures for each award.

Opposed the move to Atlanta of the National Clearinghouse for Smoking and Health and directed a letter so stating to be sent to the National Interagency Council on Smoking and Health.

Went on record as officially supporting HR-13084 and S-3074, the comprehensive school health education legislation, and the work of the PTA in the passage of these bills (the proposed legislation, in its entirety, was published in the May/June 1974 issue of *School Health Review*).

Set up a special committee to be composed of both school and community health educators to prepare a recruitment brochure, with a deadline of November 1, 1974.

Will request action by the Alliance Board at its fall meeting to allow each association to determine whether or not its student members are to belong automatically to the Association for Research, Administration, and Professionals Councils upon becoming members of the Alliance.

Moved that the name of the *School Health Review* be changed to *Health Education* (as of January 1975); that the word "health" be removed from the title of the *Journal of Health, Physical Education, Recreation*; that action be initiated to accept advertising in *Health Education*, as soon as feasible; and that the number of issues of *Health Education* be increased to eight issues per annum with the financial and editorial support necessary for this increase being provided by the Alliance as soon as possible.

Directed the Association's continuing committees to develop their respective operating codes for submission to the Board of Directors by February 1, 1975.

See also information about 1974 AAHE Convention program for Atlantic City (cover 3); nominations for AAHE officers (page 36); and nominations for AAHE awards (page 44).

Mr. CROSS. In your written statement, you refer to some of the problems in health and you talk about suicide, for instance, and congenital abnormalities. I am a little puzzled by those two specific references because in one you are talking about really maternal and child health, and I would suspect that you wouldn't get into the depth in schools on this issue that you would in a maternal and child health program.

Mrs. FENTON. I think we would be derelict in our duties if we did not. In our particular county, we have developed a marriage and family living course dealing with, you know, those things.

Many of these kids—you know, they are young. We have given them values, rather than what you do is you grow up, you fall in love, and you get married and live happily ever after, as we all know is not exactly the truth. There are some rough spots here and there, and I think we have to be prepared.

Acting Chairman MEEDS. Which part of that is not true?

Mrs. FENTON. I will talk to you about that later. [Laughter.]

But what we are trying to do is trying to get young people before they become parents to consider the responsibilities that will be their's if and when they do parent a child. It is easy to have a baby, but it is very difficult to raise that child.

I also mentioned in the testimony child abuse. This is something that we are into. We truly try to deal with these young people, especially on the senior high level, with developmental patterns of young children.

If you understand how a young child develops, then you will be less apt to abuse that child because that child, that infant, does not come up to your expectations when you feel that he should.

The neglected child—we are trying to circumvent some of these problems.

As far—well, the congenital—of course here you get into nutritional health. You get into drug education. There are so many things that affect the fetus prenatally that are influenced by these things that affect the mother and also affects, you know, the social, the mental—did I say "social"?—Emotional well-being of this mother.

Mr. CROSS. You don't see this though as substituting for the need for programs for an expectant mother, for instance?

Mrs. FENTON. No. Absolutely not. Anything you can do to fortify that will be a help, but I do think——

Mr. CROSS. It is the making the potential parents aware of the problems?

Mrs. FENTON. This is exactly what we are trying to do.

Mr. CROSS. Suicide, it seems to me, is also much along the same line. It doesn't seem to me that a health education program can really prevent suicide. All you can do is perhaps—make people aware of the value of self.

Mrs. FENTON. This in many cases would be prevention. We are dealing with mental health and certainly a comprehensive program would not circumvent, I would not think, because if you look at the testimony, many of our older people—the figures are high, I thought, for older people committing suicide. You look into the various ramifications as to why. You are talking about behavior, about human behavior.

We find, you know, especially kids in junior high school—it is not easy to grow up. It never has been. By the grace of God, you know, we all grew up, and how we made it, God only knows. We lucked out, many of us, and will continue to luck out, but many people don't have the advantages that we might have to luck out.

We are saying that during this transitional period in junior high school where there are so many changes taking place, so many physiological changes taking place, just the whole self is affected, and if you look at the rates for those young people between the ages of 14 and 25, there are many things, I think, that we in school can do to circumvent problems like that that do arise in a person's life.

The rapport that a teacher has with a kid—you cannot put a price on that. If you have a teacher that really truly cares about a kid and what happens to that kid, that is a value right there, and we are hoping that we can attract more people into health education that care about the total person.

Mr. CROSS. One final question. Do you have in Prince George's County Federal funding that helps you in these programs? Drug abuse education, title III or anything?

Mrs. FENTON. At this point we do not. We did some years ago have some Federal funds for the development of family life and human development program. There are some drug monies that might possibly be coming from the State level. We do work very closely with the service agencies within our county and there is Federal money with our DICAP, or drug interventional counseling action programs, but that is not directly in the schools, so right now we are kind of flying by on low budgets. We need things that all of us talk about in this period of recession.

Mr. CROSS. Thank you very much.

Acting Chairman MEEDS. Just one final question. Do you know any program—either Federal or State for the development and operation of a comprehensive school health program?

Mrs. FENTON. Yes. The State of Maryland, I think, made a good attempt at that with the development of the curriculum. They also gave us assist, and this was all money—I am not certain——

Acting Chairman MEEDS. Does that include teacher training in-service, preservice?

Mrs. FENTON. Yes. It includes much of that, and it was matched by county funds. Then, of course, the county has picked up on this after the State got the ball rolling.

There is one project right now. It is not a total health education problem or health education curriculum, but it is another curriculum called the AATS project which was federally subsidized. We hope in Prince George's County to use this to augment our comprehensive health education program. It is the alcohol and traffic safety curriculum developed with Federal moneys.

The State of Maryland is going to—our board of education, our State board, has accepted this curriculum so we are hoping that we will be able to pick that up and utilize aspects of it in our program in Prince George's.

Acting Chairman MEEDS. So we don't have any need for this bill?

Mrs. FENTON. We have lots of needs.

Acting Chairman MEEDS. Why do we have a need for it? You just——

Mrs. FENTON. I didn't say that, Louie, did I? Son-of-a-gun if I said it. Scratch that off the record.

Acting Chairman MEEDS. What would you do with this program in the State of Maryland if it has already provided funds?

Mrs. FENTON. You see, what we have done—We have developed something. It is not a perfect package, but it is something. It is something that can be shared with other counties, with other States, and we have done this to date.

We have many needs in Prince George's County, and Prince George's County, I told you, is the tenth largest school system. We are talking about 708,000 people. We are talking about children of these 708,000 people, and we are talking about the extension of what happens within the school going into the home.

I hope that I haven't impressed you with the fact that we have no needs. OK?

Acting Chairman MEEDS. OK.

Mrs. FENTON. You make sure now you know.

Acting Chairman MEEDS. Thank you very much.

Mrs. FENTON. Thank you for having me and God bless.

Acting Chairman MEEDS. Our next witness is Dr. Joe T. Nelson, appearing for the American Medical Association.

Dr. Nelson?

STATEMENT OF JOE T. NELSON, AMERICAN MEDICAL ASSOCIATION, ACCOMPANIED BY WALLACE ANN WESLEY, HS. D., DIRECTOR, DEPARTMENT OF HEALTH EDUCATION, AMERICAN ASSOCIATION; AND CHARLES W. PAHL, ASSISTANT DIRECTOR, LEGISLATIVE DEPARTMENT, AMERICAN MEDICAL ASSOCIATION

Dr. NELSON. Mr. Chairman and other members of the subcommittee, as you say, I am Joe Nelson. I practice family medicine in the town of Weatherford, Tex. I am a member of the board of trustees of the American Medical Association, and I am also a regent of the University of Texas Board of Regents and chairman of its Medical Affairs Committee.

Accompanying me here at the table are Dr. Wesley, who is the director of the American Medical Association's Department of Health Education; and Mr. Charles Pahl, who is assistant director of the association's legislative department.

I think for the benefit of your time, if you would, I would like to have my total statement filed for the record, and then I would either summarize or very quickly go through——

Acting Chairman MEEDS. Thank you very much. Without objection, your prepared statement will be made a part of the record at this point. You may proceed to summarize.

[Prepared statement of Dr. Joe T. Nelson follows:]

PREPARED STATEMENT OF DR. JOE T. NELSON, AMERICAN MEDICAL ASSOCIATION

The American Medical Association is pleased to have this opportunity to offer its support of the Comprehensive School Health Education Act H.R. 2599.

We commend you for your efforts to provide sound health education for all children and youth. This type of education offers an opportunity to establish patterns of living that will prevent disease and enhance personal health, thus improving the quality of their lives.

I am Doctor Joe T. Nelson, a family physician in the private practice of medicine in Weatherford, Texas, and a member of the Board of Trustees of the American Medical Association on whose behalf I am appearing here today. I am also a member of the University of Texas Board of Regents and serve as Chairman of its Medical Affairs Committee. Accompanying me at the witness table is Wallace Ann Wesley, HS.D., Director of AMA's Department of Health Education and Mr. Charles W. Pahl, Assistant Director of the Association's Legislative Department.

Since its founding in 1847, the American Medical Association has demonstrated its concern for health education of the public as an important avenue to the promotion and maintenance of the health of the American people. One important aspect of health education is health instruction of school-aged children.

In 1878, the American Medical Association's House of Delegates adopted a resolution which called upon physicians to become active in their local schools and in the development of public education for children.

Later, in 1911 the American Medical Association's concerns about health instruction and the National Education Association's interest in health services brought into existence the Joint Committee on Health Problems in Education. The Committee's overall purpose was to seek resolution of health problems of school-aged youth and to promote a well-balanced school health program.

Joint Committee statements and resolutions over the years have been influential in the establishment of school health programs. The Committee has recommended improved instruction for teachers, urged comprehensive school health instruction, and urged that health education be a separate instructional area.

Many divisions and departments of the American Medical Association carry on our concern with health education. Examples of this activity include the Communication Division's production of television and radio spots on current is also responsible for publication of the lay magazine *Today's Health*. The Department of Foods and Nutrition screens publications for scientific accuracy and makes its findings available to interested persons including school personnel and teachers.

Consultation to schools and colleges is a major activity in the overall public health education program of the American Medical Association's Department of Health Education. The Department answers many thousands of inquiries from students and teachers related to health information and school health programs. AMA staff participates in in-service workshops for teachers and nurses, produces pamphlets useful to schools, and works with professional organizations that shape school policies. The Department is responsible for encouraging cooperative action between medicine and schools at the local level.

The Association's experience in working with schools and school-aged children demonstrates to us that there is need for school health programs that are comprehensive, rather than fragmented, and which are as concerned with healthful development as with disease prevention. The legislation before you would provide the needed Federal funding and initiative which will make the development of such programs possible.

There are two major developments in our society which especially highlight the need for school and public health education. The first is the emergence of major health problems related to patterns of living. These include drug abuse, alcoholism, obesity, smoking, heart disease, and mental illness. The second is effective health care which depends on an informed and motivated population. This is particularly difficult to achieve in a highly mobile population whose health needs are addressed by a wide range of medical specialists and by other health professionals.

While it may seem to be an obvious truth, I believe that it is worth stating here that many of the nation's future health problems exist potentially in our present school population and that the nature and extent of such problems will be determined largely by how these young people manage their lives during the next 30 years. In a like manner, the way in which today's youth will use tomorrow's health care resources will also be determined by habits and attitudes developed during their school years.

It is the stated purpose of the legislation before you to encourage the provision of comprehensive programs in elementary and secondary schools with respect to health education and health problems by establishing a system of grants for teacher training, pilot and demonstration projects, and the development of comprehensive health education programs. We believe that such grants emanating from the Commissioner of Education in the manner set forth in this bill will afford the attention, priority, and resources necessary to raise the level of health instruction in our schools to a proper level. We support the overall purposes of this legislation.

While it is our belief that health instruction should emphasize healthful development and functioning, we also feel it is important and appropriate that specific disease problems and health topics be addressed as indicated by the definition in this legislation of the term "Health Education and Disease Problems." This term is defined to include dental health, disease control, environmental health, family life and human development, human ecology, mental health, nutrition, physical health, safety and accident prevention, smoking and health, substance abuse, consumer health, and venereal disease. We strongly favor a comprehensive and coordinated program of health education, and we believe that this definition will insure that meaningful programs will be developed.

We believe that it is imperative that teachers of health education be fully qualified to deal with the subject matter and pedagogy related to teaching about human health and disease. At present, most elementary and secondary teachers receive, at best, minimal preparation in these fields. Under this bill, the Commissioner would make grants to state educational agencies and institutions of higher education for teacher training with respect to the provision of comprehensive health education programs in schools. Such grants could be used by such agencies and institutions to develop and conduct training programs for elementary and secondary teachers with respect to teaching methods and techniques, information, and current issues relating to health and health problems. Well-prepared teachers will insure that the program will be able to attain its goal of providing children with meaningful education for healthful living. We support these teacher training grants.

Another important aspect in the successful upgrading of health instruction in our schools is the creation of pilot and demonstration projects to develop, test, and evaluate health education curriculums. Under the provisions of this bill, the Commissioner could make grants to state and local educational agencies, institutions of higher education, and other public or private nonprofit education or research agencies, institutions, or organizations to support pilot demonstration projects in elementary and secondary schools with respect to health education and health problems. Such experimentation is important if maximum relevancy of this program is to be achieved and if it is to develop the capacity to respond and adjust to changing health needs and priorities. We recommend support for this portion of the legislation

With regard to the program of grants to States for the development of comprehensive health education programs, it can be shown that most state education agencies have only limited resources in money and tecehnical and advisory personnel to offer educational agencies in the development and implementation of local comprehensive health education programs. Experience has shown that such state level guidance and assistance are almost a prerequisite to the development of adequate local comprehensive health education programs. Under the legislation before you, the Commissioner could make grants to state educational agencies for the development of comprehensive programs in elementary and secondary schools with respect to health education and health problems. Such grants would be available to state educational agencies for the development of such programs and for assistance to local education agencies in the implementation of such programs. This grant program will provide the financial means and incentives to bring about a full implementation of the program at the local level.

The final provision which I would like to comment upon relates to the authority under Section 5(c) which permits the use of pilot and demonstration project grants for the evaluation of health education curriculums and training programs. In reading this legislation, we interpret this to be a permissive use of the funds rather than a requirement to evaluate the programs funded under this legislation: We believe that a provision must be included in the legislation

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which would require that an evaluation of the programs be undertaken. Only through such an evaluation process can it be determined whether the program is effectively attaining the goals for which it was enacted. We would urge that the legislation be amended to require that program evaluations be a part of the overall health education effort.

While some good health education is going on in the schools of this nation, it is apparent that health education has extremely low priority in program development, funding, and administrative commitment. The unfortunate fact is that most children and youth of the nation now do not have an opportunity to participate in comprehensive health education programs, since health education in many schools either is nonexistent or is provided on a framgmented and inadequate basis.

The Comprehensive School Health Education Act can held build into the primary and secondary education of every American child a program of health instruction that will help establish patterns of living that we know will discourage disease and enhance health, including those patterns related to the use of health services. Such developmental and sequential health education has great potential for enhancing the quality of life and raising the level of health for the student's lifetime by significantly reducing those health problems susceptible to educational intervention and by favorably influencing the learning process. We urge your support of this legislation and that you work for its enactment by the Congress.

Mr. Chairman, this concludes our formal statement. We appreciate the opportunity to offer our views on this legislation and will now be happy to try to answer any questions which the Committee may wish to ask.

Dr. NELSON. Of course, the American Medical Association has been interested in this since its founding, in that we believe that promotion of good health care at the earlier ages leads to a healthier later life, and in fact as early as 1878 our House of Delegates adopted a resolution which asked for the physicians in their local levels to get themselves involved in local schools and public education of the children of this country.

Then in 1911 again the AMA re-expressed our concern along with NEA's interest in health services and brought into existence the joint committee on health problems in health education.

That, I think, is a little bit of the background. I think what might be of interest to the committee are many of the pamphlets that go back—if the committee would like, we would be happy to leave these with you. They address some of our activities in this area such as drug dependence, alcoholism, immunizations, blood pressure, why health education in your schools, finding yourself, the miracle of life, many pamphlets.

Acting Chairman MEEDS. Without objection, the packet of information which has been presented by Dr. Nelson will be made part of the file. This is for us, is it not?

Dr. NELSON. Yes, it is.

I think you would be also interested in knowing that the department that Dr. Wesley heads in our Chicago office receives approximately 1,000 calls a month from either educators or people concerned with health education, in which that department keeps a quite active operation going.

I think you, as well as the other authors of this bill, are to be commended because for one of the few times we approach and look at this bill and support it on the basis that it is a total coordinated effort of a comprehensive health program.

I think that you are probably wise in doing it on a permissive basis, or, if you will, a pilot program to find out whether it is going

to be worth your while to continue to spend the taxpayers' money in this area.

I think you have taken an excellent approach in addressing the two areas. One: as to the teacher training in-service and preservice; two: to the institutions, and then the evaluation and critique of the curricula that have been developed and have been demonstrated in your pilot projects that you propose in your bill.

On that basis, I think that you have done an excellent job in drawing together a very complex subject into what would appear to be a relatively simple bill, and that almost frightens you when you see one this simple, that somebody is going to bother it, and we think it is an excellent bill in its current form.

The thing that I think—is that it will lead, if it proves to be successful, to the eventual betterment of the quality of life to the American public, and, by so doing, then the other needs, as the gentleman referred to earlier, such as national health insurance and some of these other programs become of less importance.

Basically, we do support the bill and we like your approach to it. We would like to see probably, as this becomes more operable, it coordinated and some of the fragmentation of other programs phased out and incorporated into the current bill.

As you know, our society—and we all react more or less to a crisis type of orientation, be it drug alcohol, tobacco—and I think probably one of the most recent examples is that we have been promoting self-examination of the breast for many, many years by the women, and also encouraging them to see their doctors, and teach them how to do self-examinations, but until some impact is publicized in the media and what not, then it is brought into focus and you get a crisis-type program.

We would like to think that it would eventually take care of all of the crisis-type programs and be brought into a total picture of a comprehensive health education as related to health problems.

With that, Mr. Chairman, I think, rather than my continuing to elaborate, I would be probably more helpful to you in attempting to answer any questions you might have.

Acting Chairman MEEDS. Thank you very much, Dr. Nelson. Dr. Wesley, did you have anything to add before questions?

Dr. WESLEY. I think my reaction—I have been here the 2 days, and I think that it has been covered very well. I would agree with what I have heard. I would emphasize—It seems to me as a health educator that I see that everybody needs to think of this as long-term project. I think that so often health education is looked at as a panacea, and we suddenly stick our thumb in the dike.

I am concerned that if we are realists and we do think that people ought to learn about themselves, we have a series of growth and development, deciding what you want to know and that type of thing in health education. This takes a long time, and it will need to be evaluated.

I think that we shouldn't expect too much too soon, but it is a good piece of education.

Acting Chairman MEEDS. Thank you very much. Thank you both. Mr. Pahl?

Mr. PAHL. No, I don't.

Acting Chairman MEEDS. First, let me express my appreciation for your testimony. I have had an opportunity to read over your's very rapidly, Dr. Nelson, and I appreciate some of the points that you have made. I am especially struck by your statement that—on page 3—there are two major developments in our society which essentially highlight the need for school and public health education.

First is the emergence of major health problems related to patterns of living.

Dr. NELSON. OK. Let me elaborate on that.

Acting Chairman MEEDS. I wish you would.

Dr. NELSON. For instance, in some of the programs we have observed in some of the more advanced schools, you know, who have been aggressive in health education where we are exposing a child at the primary level to some health education, particularly, say, within an inner city area, then we find the parents of the child wanting to be just as smart as their children are, and they are coming in and asking for the same information because they do not want to be ignorant, and for the first time you are stimulating some of these people, and this is sort of the emerging pattern of living that we see, and we think this bill would eventually address itself as a long-term solution to part of this.

Acting Chairman MEEDS. A lot of the things you point out are not of relative recent occurrence, but the degree to which they are occurring in this society is so much greater than in the past.

I have termed these cultural diseases in which drug abuse, obesity, things like this, are a part of a more sedentary type of living which exists today.

Dr. NELSON. Well, we totally agree, and it probably is a result partly of our enjoying an affluent society currently. Now, I happen to be of the age bracket that goes back to the days of the depression, and if you stop and think back, in those days we probably didn't seek as much medical attention, but, because of basic diet structures and patterns of living that we were forced to abide by due to economics, we probably had a total healthier population than we do today.

Today, I think, we are enjoying our affluence. If the current recession continues, we may not enjoy that. [Laughter.]

Acting Chairman MEEDS. I had a question when I first listened to your testimony. I thought what a great idea it would be for the American Medical Association to participate with universities, elementary and secondary school districts, in the development of curriculum, in development of teacher training programs, and things like that. The bill does provide that the Commissioner may make grants to State and local educational agencies, institutions of higher education, and other public or private nonprofit education or research agencies, institutions, or organizations to support— —

Dr. NELSON. That is in the first part of your bill.

Acting Chairman MEEDS. Right. Do you consider yourself to be public or private nonprofit education or research agency?

Dr. NELSON. We are involved in all of those at some level. I am not sure that we would be the proper vehicle. We might be a part of a total picture.

Acting Chairman MEEDS. That is what I mean. Obviously you would bring a special expertise to it, an overall approach.

Mr. PAHL. Mr. Chairman, the American Medical Association certainly qualifies under the parameters of the law for that kind of thing. I think that perhaps Dr. Wesley can comment a little bit because I think the Association's activities are relatively extensive in that area right now.

Dr. WESLEY. Yes, I would like to. At the national level, we participate with local level physicians and groups like this. The fact is, we hold a physician, school, and community conference every 2 years in which we bring this all together.

We hope that advisory committees for schools will be made up of persons including physicians and so that through this direction we do what you are saying, because physicians do participate as school board members, as you know, but a lot of them do work in the school health committee that exists in that community, and most State societies do have a school health committee that reaches out and works with anybody who really would like to have any help.

The other way is that the staff does work with specific problems very often, with inservice education of teachers or preservice, but once in a great while we participate in kinds of consultations.

As far as research is concerned, we have some examples of that. Winston Park, Ill., for example.

Acting Chairman MEEDS. In this regard, though, I would think your expertise or that perhaps of a medical school would be very good in helping devise teaching training programs.

Dr. NELSON. Well, we do this.

Acting Chairman MEEDS. You may do it with physicians.

Dr. NELSON. We also do it in what—Since I am a regent of the University of Texas, I will tell you how we do it with the University of Texas. That is, we bring the focus on this into what we call our allied health school of professions. Through that vehicle then we also set up over the State seminars on an invitational basis to communities and provide programs primarily inservice to the local communities or to the local faculties of schools, to provide them with this, and they can also come and take more or less what we would term an intensive review course, an update, or a refresher course in health needs or health curriculum.

Acting Chairman MEEDS. That is the University of Texas?

Dr. NELSON. Yes, sir.

Acting Chairman MEEDS. Very good.

Dr. NELSON. We have four of these in our system.

Acting Chairman MEEDS. Chris?

Mr. GROSS. One question, Dr. Nelson. The bill speaks throughout of the Commissioner making grants and in section 8 it talks about the Commissioner providing technical assistance. Mr. Meeds has brought to light the potential role of the AMA and medical societies. Perhaps technical assistance should also be provided by the health agencies, perhaps under the Assistant Secretary for Health or directors of the various health units in HEW.

I wonder what your reaction might be to that.

Dr. NELSON. Well, as you know, you already have programs funded over there. Just let me use NCI, the National Cancer Research In-

stitute. They provide a lot of this besides the research dollars that they do, but they would be a prime example of technical assistance to the Commissioner, and I think in the language of your bill that you actually say the Commissioner has the prerogative or right to call on any agent or agency of the Federal Government for this assistance.

Certainly there are many areas—NIH, National Institute of Health, and National Institute of Medicine—There is just no end. Public health service. No end to the resources that the Commissioner has available to him.

Mr. CROSS. I suspect it would make the health agencies feel a lot more responsible if they were named in the statute, however, as responsible for this, rather than just as subservient to the Commissioner.

Dr. NELSON. Then what would you do with the ones that you omit unintentionally?

Mr. CROSS. A way to handle it is just to say, "the Assistant Secretary for Health and the Commissioner," or something of that sort.

Dr. NELSON. That would be acceptable.

Dr. WESLEY. I think at the local level, to follow up on what Dr. Nelson has said, we feel as if school curriculum and that sort of thing really quite often should call in all sorts of help, and we said medicine, but this is not to eliminate the different kinds of health agencies that exist, official and voluntary, as an advisory group, because physicians don't pretend to be experts in curriculum or education. We need the educator for this, but they do have, as Dr. Nelson pointed out, inservice education which is up-to-date information, and we feel the voluntary agencies have, for example, very specific information on something like cancer and that sort of thing which should also appear in the curriculum.

Mr. CROSS. Do I understand your suggestion that perhaps something that might be considered is an advisory group at the local level which would incorporate the school and these health-related associations?

Dr. NELSON. This is right, but the agencies should be interpreted, we think, as us and dental and——

Mr. CROSS. Public health people and all the rest. Very interesting. Thank you, Mr. Chairman.

Acting Chairman MEEDS. Thank you all for a very fine testimony and thank you very much for your support.

Dr. NELSON. Let me thank you, Mr. Chairman, on behalf of the other two persons with me for your attention, and we certainly support your efforts.

Acting Chairman MEEDS. Thank you very much.

The next witness is Mr. Leonard Wheat, special assistant, American Dental Association. Mr. Wheat?

[No response.]

Acting Chairman MEEDS. Is Mr. Wheat here?

Mr. STAUFFER. Good morning sir. Mr. Chairman, our written testimony was submitted by Dr. Robert Kaplan, of Cherry Hill, N.J., but because of a sudden illness he was not able to be with us today, and I am named in the written testimony, Delmar Stauffer,

director of the Bureau of Dental Health Education, the American Dental Association, and I would like to appear at this time.

Acting Chairman MEEDS. Very good. Without objection, the written testimony will be made a part of the record at this time, and you may proceed to represent the American Dental Association in this testimony.

Mr. STAUFFER. Thank you.

[Prepared statement of Delmar Stauffer follows:]

PREPARED STATEMENT OF DELMAR STAUFFER, BUREAU OF DENTAL HEALTH EDUCATION, AMERICAN DENTAL ASSOCIATION

The American Dental Association is pleased to have this opportunity to present its views on H.R. 2600, the Comprehensive School Health Education Act.

The Association supports this bill because we believe it will improve the health of our nation's young people now and will provide them with an excellent foundation for continued improvement in healthful living as they mature and become parents of the next generation of Americans.

The Association advocates special attention to the dental health care of children, as recorded in a long listing of policy actions, because it is evident to the dental profession that preventing dental disease in children has the greatest potential for improving the dental health of our nation's population and reducing or eliminating the present backlog of unmet dental needs.

The Association has long supported the concept that the school setting offers a unique opportunity in which to teach health concepts and principles to students during their formative years and to motivate them to use these principles wisely in accepting personal responsibility for their dental health.

From the point of view of dental health education, it is imperative to teach children while they are very young and before their dental needs multiply and compound.

The Association's Bureau of Dental Health Education has been working for many years on the implementation of a comprehensive dental health education program for schools from kindergarten through 12th grade, to be conducted by regular teachers. The Bureau produces numerous educational booklets and audiovisual materials for the teaching of dental health in elementary and secondary schools. Pamphlets and motion pictures relating to nutrition and dental health have been widely distributed to school children. The Association also releases nine public service television spots each year to 600 commercial television stations. Through state dental societies the Bureau has conducted teacher training workshops in dental health education for elementary school teachers as well as training sessions for dentists on how they can best contribute to school-based dental health programs. A 1972 Association policy calls on "constituent and component dental societies to work with school boards and other appropriate groups to assure that dental health education programs in schools are based on current information on oral hygiene and preventive dentistry."

In addition to the Association's own curriculum, a variety of other school preventive dental health education programs are in effect, testing various means of teaching youngsters the necessary techniques of home oral hygiene that will enable them to protect their own dental health.

In 1960, the American Dental Association House of Delegates went on record as supporting a strong program of health education as a basic part of the school and college curriculum and officially encouraged its state and local societies to work with the appropriate health and education officials and agencies in their communities to achieve this end. In 1973, the American Dental Association voiced its concern for the health of school children by testifying on the Child Nutrition Education Act and the use of food service vending machines in schools.

The American Dental Association support comprehensive health education which incorporates all the areas of health education and health problems as listed in the bill, of which dental health is a specifically named part. We would like to present for the Committee's consideration an overview of dental health in this country and the great potential that we feel this bill has for reducing

the extent of dental problems as well as their costs. As you probably know, dental disease is rampant in the United States, with tooth decay the most commonly occurring problem. The total dental health bill of this country is approximately $6 billion annually and the expenditures cover only the 45% of the population which seeks dental care annually. Of this total, 40%, or nearly $2.5 billion, is spent for the restoration of decayed teeth. Yet tooth decay is one of the most preventable of all dental problems. Faithfully following a few simple rules of oral hygiene, including regular brushing and flossing and eating a balanced diet, would prevent most tooth decay from occurring.

Children are particularly prone to suffer from tooth decay. By age two, approximately 50% of our children have tooth decay. On entering school, the average child has three decayed teeth and by age fifteen, the average child has eleven decayed, missing or filled teeth. Approximately 50% of children have gingivitis, which can lead to progressive periodontal disease, a major cause of tooth loss in adults.

Clearly, much needs to be done in the areas of motivating children to care for their teeth beginning at an early age, and to see that they receive proper dental care when it is needed. The American Dental Association believes that if dental health is included in and related to a total school health education curriculum, such as is proposed by this legislation, that dental health will be greatly improved and the cost of providing it will be greatly reduced.

A health education program which includes dental health as one of its components can be expected to provide the following benefits: (1) Fewer cavities in the young; (2) less periodontal disease in these children now and after treatment, thus allowing more money to be available for other dental and reaching adulthood; and (3) less money spent on dental bills for restorative health needs.

With passage of the legislation under consideration, we can increase the total dental health knowledge of the children in the nation and develop positive dental health habits in youngsters during their most impressionable learning years.

As with many of the other areas of health covered by this legislation, prevention is the key that will unock the door to a lifetime of better dental health at lower cost. In recent years there has been a renewed emphasis on preventive dentistry. The American Dental Association House of Delegates has created the Coordinating Committee on Preventive Dentistry and one of the 11 specific goals of the Committee is to "encourage elementary and secondary education to add prevention in dental health to the curriculum." This we believe can be done most effectively through the legislation which you now have before you.

We believe that a central value of this legislation lies in its comprehensive approach to health education. The heretofore fragmented approach to teaching about health by emphasizing separate disease entities will be replaced by an emphasis on integrating all aspects of health that affect an individual and in turn relating health to other aspects of the curriculum. The child who can relate facts he has learned to his everyday existence will be better able to take responsibility for his health.

Through provision of teacher training, pilot and demonstration projects, and the development of comprehensive health education programs in schools, the legislation you are considering can help: (1) Build a reliable fund of knowledge about health education techniques; (2) train teachers to effectively implement health education programs in their classrooms; and (3) motivate our nation's young people to assume intelligent responsibility for their own health.

The American Dental Association joins with its colleagues in other health professions in stressing the need for a comprehensive health education program in our schools and in supporting the legislation under consideration as the most effective way to achieve this end.

STATEMENT OF DELMAR STAUFFER, DIRECTOR, BUREAU OF DENTAL HEALTH EDUCATION, AMERICAN DENTAL ASSOCIATION

Mr. STAUFFER. As I said, Dr. Kaplan is unable to be with us this morning. He extends his apologies. It is not a serious illness and he will be on his feet very soon. Dr. Kaplan is a full-time private prac-

titioner, restricting his practice to dental care of children. He is also president of the American Academy of Pedodontics and vice chairman of the Council on Dental Health of the American Dental Association, and it was in that capacity that he has submitted his written testimony.

As I stated I am Mr. Delmar Stauffer, director of the association's bureau of dental health education. I am pleased to have this opportunity to offer testimony in support of the Comprehensive School Health Education Act.

The association supports this bill because we believe it will improve the health of our Nation's young people now and will provide them with an excellent foundation for continued improvement in healthful living as they mature and become parents of the next generation of Americans.

The association advocates special attention to the dental health care of children, as recorded in a long listing of policy actions, because it is evident to the dental profession that preventing dental disease in children has the greatest potential for improving the dental health of our Nation's population and reducing the ever-increasing cost of remedial dental procedures.

The association has long supported the concept that the school setting offers a unique opportunity in which to teach health concepts and principles to students during their formative years and to motivate them to use these principles wisely in accepting personal responsibility for their dental health.

From the point of view of dental health education, it is imperative to teach children while they are very young and before their dental needs multiply and compound.

The association's bureau of dental health education has been working for many years on the implementation of a comprehensive dental health education program for schools from kindergarten through 12th grade, to be conducted by regular teachers.

If I may pause, Mr. Chairman, I have a sample of our comprehensive curriculum guide for dental health education in the schools, which, if you would like, I would like to leave and have it become part of the file.

Acting Chairman MEEDS. Very good. Without objection, it will be made a part of the file at this point.

Mr. STAUFFER. The bureau produces numerous educational booklets and audiovisual materials for the teaching of dental health in elementary and secondary schools. The association also releases 9 public service television spots each year to 600 commercial television stations.

Through State dental societies the bureau has conducted teacher training workshops in dental health education for elementary school teachers as well as training sessions for dentists on how they can best contribute to school-based dental health programs.

A 1972 association policy calls on "constituent and component dental societies to work with school boards and other appropriate groups to assure that dental health education programs in schools are based on current information on oral hygiene and preventive dentistry."

In 1960 the American Dental Association House of Delegates went on record as supporting a strong program of health education as a

basic part of the school and college curriculum and officially encouraged its State and local societies to work with the appropriate health and education officials in their communities to achieve this end.

In 1973, the American Dental Association voiced its concern for the health of schoolchildren by testifying on the Child Nutrition Education Act and the use of food service vending machines in schools.

Our purpose was to support programs that emphasize the importance of motivating schoolchildren to form habits and attitudes related to sound health practices.

The American Dental Association supports comprehensive health education which incorporates all the areas of health education and health problems as listed in this bill, of which dental health is a specifically named part.

We would like to present for the committee's consideration a brief overview of dental health in this country and the great potential that we feel this bill has for reducing the extent of dental problems as well as their costs.

As you probably know, dental disease is rampant in the United States, with tooth decay the most commonly occurring problem. The total dental health bill of this country is approximately $6 billion annually and the expenditures cover only the 45 percent of the population which seeks dental care annually.

Of this total, 40 percent or nearly $2.5 billion is spent for the restoration of decayed teeth. Yet, tooth decay is one of the most preventable of all dental problems.

A school health education program which would motivate children to follow the proven rules of oral hygiene, including regular brushing and flossing, eating a balanced diet, and the use of fluorides, would prevent most tooth decay from occurring.

Clearly, much needs to be done in the areas of motivating children to care for their teeth, beginning at an early age, and to see that they receive proper dental care when it is needed.

We believe that if dental health is included in and related to a total school health education curriculum, such as is proposed by this legislation, that dental health will be greatly improved and the cost of providing it will be greatly reduced.

A health education program which includes dental health as one of its components can be expected to provide the following benefits. First of all, fewer cavities in the young. Second, less periodontal disease in these children now and after reaching adulthood. Finally, less money spent on dental bills for restorative treatment, thus allowing more money to be available for other dental and health needs.

As with many of the other areas of health covered by this legislation, prevention is the key. It will unlock the door to a lifetime of better dental health at lower cost. In recent years there has been a renewed emphasis on preventive dentistry.

The American Dental Association House of Delegates has created the Co-ordinating Committee on Preventive Dentistry, and one of the 11 specific goals of the committee is to "encourage elementary and secondary education to add prevention in dental health to the

curriculum". This, we believe, can be done most effectively through the legislation which you are now considering.

The value of the proposed bill lies in its comprehensive approach to teaching about health by emphasizing how various aspects of health are interrelated and how health relates to other aspects of the curriculum.

The child who can relate facts he has learned to his everyday existence will be better able to take responsibility for his own health.

The provisions of the legislation you are considering can help: (1) To build a reliable fund of knowledge about health education techniques; (2) to train teachers to effectively implement health education programs in their classrooms; and (3) to increase awareness of and appreciation for personal health, thereby preventing considerable disease and disability and reducing the ever-increasing cost of remedial medical procedures; and (4) to enable students, as future adult citizens, to assist their communities in resolving dental and medical problems through the establishment of educational and control programs.

The American Dental Association joins with its colleagues in other health professions in stressing the need for an up-to-date and comprehensive health education pogram in our schools and in supporting the legislation under consideration as the most effective way to achieve this end.

We appreciate this opportunity to testify in support of this legislation.

Acting Chairman MEEDS. Thank you very much, Mr. Stauffer.

Mr. Stauffer, you have heard one of the earlier witnesses testify about—and I think talking about in the fifth grade—comprehensive physiological teaching of parts of the body.

Do you think it is possible to really have young people understand and appreciate what dental health means without having some understanding of what happens to the body?

Mr. STAUFFER. Well, I think this is best answered in that we like to think of the total individual and, as that total individual grows and becomes aware of different parts of his body, he is able to comprehend more of the various aspects of the educational treatment that he is given or he is subjected to.

Now, at a specific age—and it is difficult to say exactly what the child will feel for his dental health, for example, but we do know through our programs to date that children are quite interested at the early elementary ages because of the changing of the dentition. The primary teeth are being lost in the early grades and they are getting their permanent teeth, and this to them means, of course, that they are growing and they are becoming adults. Then an appreciation and awareness of the oral health also is rather apparent to them, and they become very interested in it.

As a matter of fact, we have capitalized on this in some of the approaches to the dental health education in that by the junior high age they are quite interested in interpersonal relationships and with kissing and other means of affection, and this has been——

Acting Chairman MEEDS. Takes on a new significance to them.

Mr. Stauffer. Yes; all of a sudden they are now aware of their smile more than they ever were before, so I would say "yes," that

probably and given time, although it would be difficult to pinpoint exactly what their appreciation or awareness is, it is a growing and continuous program of education for them.

Acting Chairman MEEDS. If you just isolate brushing teeth, other oral hygiene, it really doesn't make too much sense to the young person. It is rote learning, and it seems to me that it has to fit in with a comprehensive study of what the heck is going on with one's physical being.

Mr. STAUFFER. Exactly.

Acting Chairman MEEDS. And to merely—I can remember in grade school being taught about brushing my teeth and it really didn't make much of an impression on me because I didn't have the other thing I just described. I didn't know how it related to my total physical being.

Of course, I was told if I brushed my teeth I would keep them, and if I didn't I would lose them, one of those scare—like the VD movies we used to get in the Navy—one of those scare tactics. It just really didn't make much of an impression on me.

Mr. STAUFFER. Yes; we realize that, and that is one of the considerations that we have kept uppermost in our minds as we have developed what we consider a comprehensive health education prevention oriented program. This is a sample of that program, and never do we go on record as wanting to enter the educational field with just a package of dental health education. We want it related to a total comprehensive program of health education because of the type of thing that you are pointing out, and we have done this in different grade levels.

This is the packet for level 2. We have a curriculum guide, K–12, and it is divided up into four levels, kindergarten through second grade—through third grade, four through six, seven through nine, junior high, and then high school.

We work on what an early professor in health education, Howard Holman, has called a spiralling curriculum where the things are interrelated because we are talking about a total person, and that person in his environment.

In the second level, which would be fourth, fifth, and sixth grades, we have such concepts here as brushing and flossing, yes, but also we relate the dental health to nutrition, also the tooth in its environment, diseases, and harmful habits.

They have to realize that there are safety factors that should be considered and also playground activities and that type of thing, use of mouth guards and how they are used in sports, et cetera, also emergency procedures and then being an intelligent health consumer.

We have tried to relate the dental health to the total aspect of the individual, and we don't want to go in and just talk about health education in terms of brushing and flossing.

Acting Chairman MEEDS. Dental health has to be an integral part of nutrition education, doesn't it, to be meaningful?

Mr. STAUFFER. Frankly, it is ridiculous to separate them, and we are finding that more and more to be true. While we did not in our statement say much about periodontal disease, we have through the years found that one of the most proven prevention methods has

been fluoridation of water supplies, which has cut down anywhere from 50 to 60 percent of the decay.

However, we are not forgetting about dental disease in terms of decay. There is still a lot of research going on in this area, but we are also interested in periodontal disease because we have found increasingly that adults don't lose their teeth to decay, but because of periodontal disease, which is actually an infection that is continuous and grows to the point of your losing the bones that support the teeth, and they fall out as a result, so this is also something that interrelates to the whole total package of health education.

The beginning of the digestive tract, of course, being with the oral cavity, is an important aspect and an easy way to relate it to the system approach to health education.

Acting Chairman MEEDS. Again, your testimony, I think, points up that—the necessity of a comprehensive approach to this thing. While you have been involved in dental education for a long time and health education has been involved in dental education for a long time, it has been sporadic, spotty, and not comprehensive, and as a result probably not nearly as effective as it ought to be.

Chris?

Mr. CROSS. I wonder if you could respond to the points that were brought out with the previous witnesses from the AMA, about the advisability of an advisory council at the local or State level, as well as the question of having technical assistance provided also by the health side of HEW as well as by the education side.

Mr. STAUFFER. Yes. I think we can make a couple of points in that regard, the first being that the American Dental Association, like the American Medical Association, is quite interested and eager to to work with the school systems on a pyramidal type effect where we work especially with the State societies in dentistry.

We have naturally a State component to the American Dental Association as well as local components, and much of our work is done at the State level of dental societies. This is an avenue for reaching and contacting the school systems.

An example of this is Ohio right now which is working on developing a comprehensive health education program. They in particular are starting to work with our dental program as a model, and the Ohio Dental Association is working with the Ohio Department of Education and the Ohio Department of Public Health.

In this regard, the three are working together to try to implement a dental health education program for all the schools throughout the State, so we feel that we have the people who are willing to volunteer for this type of thing.

We woud be happy to give expert testimony or expert help, et cetera.

Second, it is our understanding that one of the functions of the new Bureau of Health Education at the Federal level of the Center for Disease Control in Atlanta, Mr. Horace Ogden, would be one of our hopeful people in coordinating the work of setting up a comprehensive health education——

Acting Chairman MEEDS. What was that again?

Mr. STAUFFER. A Bureau of Health Education.

Mr. CROSS. What agency is that under?

Mr. STAUFFER. It has been established, I believe, as a part of the Center for Disease Control in Atlanta, Ga. under Dr. Sensor.

Acting Chairman MEEDS. So it is under NIH?

Mr. CROSS. They now have five health agencies, and I have lost track of them. We can find out.

Acting Chairman MEEDS. At least it is under HEW.

Mr. CROSS. Yes. Dr. Sensor?

Mr. STAUFFER. Yes. Dr. David Sensor.

Acting Chairman MEEDS. Dr. David——

Mr. STAUFFER. Sencer, S-e-n-c-e-r.

Mr. CROSS. So you think then that they would be helpful?

Mr. STAUFFER. I think they would be helpful. We have met with Mr. Ogden, who is the Director of the Bureau, a couple of times already, as have the witnesses here from the American Medical Association, and it is our understanding that one of the roles of the new Bureau of Health Education from the Federal level would be to try to coordinate the activities for health education. That is, finding expert testimony and witnesses and committee members for consultation throughout the various agencies of the Federal Government.

Mr. CROSS. Very interesting. I am glad you mentioned that.

Acting Chairman MEEDS. If you will yield, Chris. But not for the purpose of health education in the schools?

Mr. STAUFFER. Well, I thought the question was that at the Federal level, if you are talking about various people who would have expertise——

Acting Chairman MEEDS. An aid.

Mr. STAUFFER. Yes.

Acting Chairman MEEDS. You mentioned the Bureau of Health Education. That Bureau's function is not teaching health education in schools.

Mr. STAUFFER. No, it is not.

Acting Chairman MEEDS. Which is what this bill deals with, the development of programs to do that.

Mr. CROSS. Fine. Thank you very much.

Acting Chairman MEEDS. Thank you very much, Mr. Stauffer. We appreciate your testimony and the support of your association.

Mr. STAUFFER. Thank you.

Acting Chairman MEEDS. That then concludes the first 2 days of hearings on H.R. 2600 and related bills and I would like before adjourning the subcommittee to thank all of you who have testified and all of those of you who represent organizations that have given their support to this legislation. It is very helpful.

Your testimony has been excellent and we hope we can respond as a subcommittee.

Thank you all. The subcommittee is adjourned.

[Whereupon, at 11:35 a.m., the subcommittee adjourned.]

[Letter submitted for inclusion in the record follows:]

CAPITOL AREA COMPREHENSIVE HEALTH PLANNING ASSOCIATION,
East Lansing, Mich., July 15, 1975.

Congressman JAMES O'HARA,
Rayburn House Office Building,
Washington, D.C.

DEAR CONGRESSMAN O'HARA: The Capitol Area Comprehensive Health Planning Association urges you to give strong support to the Comprehensive School

Health Education Bill (HB 2600 and S 533) presently under study by Congress. CACHPA believes this legislation makes good sense for the following reasons:

(1) the legislation recognizes that our traditional health care system is essentially geared to treating people *after* they become ill and that this approach must be complemented with a greater concern for preventing illness and promoting good health;

(2) the legislation recognizes that good health is first of all the responsibility of the individual and that the personal health practices of our citizens have a major impact on determining our nation's level of health;

(3) the legislation recognizes that good (and bad) health practices are learned and that the most appropriate time for this learning to take place is during the formative years before poor health habits are already developed; and

(4) the legislation proposes to focus monies where they are most critically needed, i.e. toward developing skilled health educators and sound, comprehensive health education curricula.

Our recent study of our local school systems and our review of the status of health education statewide and nationally, leave no doubt that school health education should become a top priority issue in the coming years.

Your vigorous support on behalf of this legisation would be most appreciated.

Sincerely,

RAYMOND FEDERAU,
Chairman, Board of Trustees.

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